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ABSTRACT

The Washington State Department of Social and Health Services (DSHS) was created as an umbrella agency, to bring together state human service programs, so that people could get comprehensive assistance with many, often interrelated needs. Efforts were made to co-locate various service program offices to make access to various services easier. Later specialization of staff and separate funding and accountability requirements resulted in separate, often uncoordinated service plans for the same client, implemented by various case managers. Against this "maze of eligibility," DSHS leaders counter-posed the image of "No Wrong Door"-- a vision of human services in which clients get fully coordinated, comprehensive services no matter where or how they enter the system. The long-term design included not only better coordination and service integration among different program staff within DSHS, but also teamwork with natural supports and with community partners. This report presents the key elements of that long-term design and new No Wrong Door startup programs. Four appendixes include the complete No Wrong Door model, a coordinated services charter, and presentation slides. (GCP)

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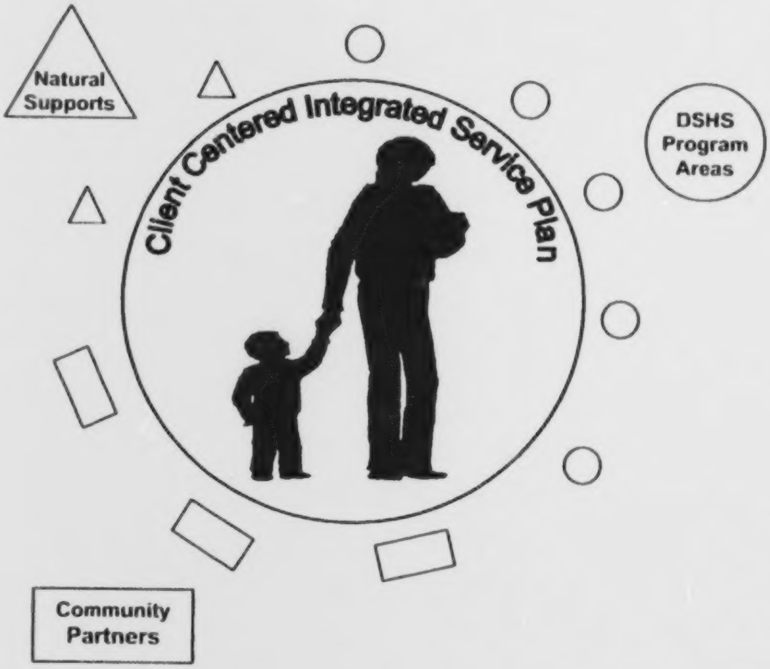

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WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MANAGEMENT SERVICES ADMINISTRATION
RESEARCH AND DATA ANALYSIS DIVISION

Early Experiences in Service Integration:

What We Can Learn from No Wrong Door Startups

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August 2003

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EXECUTIVE SUMMARY

Context and History

The Department of Social and Health Services (DSHS) was created as an umbrella agency, to bring together state human service programs, so that people could get comprehensive assistance with many, often interrelated needs. Efforts were made to co-locate various service program offices to make access to various services easier.

Later specialization of staff and separate funding and accountability requirements resulted in separate, often uncoordinated service plans for the same client, implemented by various case managers. A holistic, customer centered view was often lost to specialized eligibility requirements. The result was a maze of eligibility doors, and encounters with various social/health providers with different perspectives who did not communicate with each other about the needs of shared clients.

No Wrong Door (NWD) Long Term Design

Against the maze of many doors, DSHS leaders counter-posed the image of "No Wrong Door" – a vision of human services in which clients get fully coordinated, comprehensive services no matter where or how they enter the system. The No Wrong Door project began in 2001 by gathering data, information on local initiatives, and the advice of national experts and experienced, innovative front line staff from the various service program areas. They proposed new values, more coordinated practices and a model of how a holistic, client centered system could work, in the long run.

The long-term design included not only better coordination and service integration among different program staff within DSHS, but also teamwork with natural supports (family, friends, community groups) and with community partners (other government agencies and private community organizations). The key elements of that long-term design are shown on pages 11 - 12 and the complete model is defined in Appendix 1 of this report.

No Wrong Door (NWD) Startup Requirements

In 2002, the NWD startups began by concentrating on subgroups of difficult and costly clients who were already receiving multiple services from DSHS.

Improvements were sought first in practical, program-relevant outcomes for DSHS shared clients.

***For long term WorkFirst clients*:**

- Helping them cope with multiple issues in their lives
- Getting them employed sooner.

For state-dependent youth coming out of rehabilitation institutions:

- Helping them get more family and community support
- Reducing further criminal recidivism
- Reducing placements in costly foster care and group care facilities.

For people with multiple disabilities experiencing crises:

- Finding creative new ways to keep them healthier and safer
- Reducing more costly crisis interventions.

Some crucial elements of the NWD long-term design were postponed:

- A broader inclusion of natural supports, other agency and community partners.
- Early identification and screening of multiple needs when they first arose rather than when they were first served (early intervention practices).
- A more customer and community driven, holistic definition of desired outcomes.
- The development of new tools (screening, communication and data sharing tools), and new strategies (increased flexibility in funding and co-locating staff).

Findings from the Early Experiences of the NWD Startups

Major Achievements

Better coordination among DSHS staff – Staff at the local level (in six of the seven startups) successfully implemented better, coordinated ways of serving shared clients. They were excited about working in new ways that are better for both clients and for staff. Clients have a voice and become engaged. Staff gets input from the client, they create agreed upon plans, and they share responsibilities and achieve holistic outcomes.

More complete service integration – Two startups actually went beyond the startup requirements. They implemented almost all the elements of the NWD long term design, including:

Natural supports and some community partners;

Earlier detection of multiple needs and earlier intervention;

Using a more client centered, strength based approach.

Better client outcomes – Staff reported that client outcomes were clearly better with more service integration. They were particularly better when clients were successfully engaged, engaged earlier and consistently supported.

Major Perceived Challenges

The main challenges identified across all startups were the following:

Client resistance to participation – This seemed to occur more when clients were reached late, after they experienced failures in dealing with the multiple issues in their lives, lost trust in their own or others' abilities to help, or when challenging behaviors became 'chronic.'

Staff resistance to participation – Startups experienced difficulties in getting all DSHS programs and other agency and community parties potentially involved to 'come to the table,' and consistently participate. A specific concern was with difficulties imposed by turnover of staff, since it disrupts newly formed relations of trust and newly established collaborative networks.

Inflexible funding – Difficulties in 'redirecting' funds or using funds in more flexible ways became barriers. This was especially problematic since extra funding for NWD startups was not available in a period of overall funding and staffing cuts. Staff suggested that up-front costs for NWD initiatives could be funded from possible cost-savings, avoiding more expensive services in the same program, other programs, or from preventing further future costly services.

Staff Suggestions on Key Policy Issues to Resolve for Next Steps in Service Integration

'Front-End or Back-End' Integration – Many startup staff wondered whether better client outcomes and more cost savings could be achieved by shifting the focus:

> From multiply served, complex, high-risk, high-cost clients and coordination of plans and services within DSHS programs,
>
> To an earlier identification of people with multiple needs and early interventions in partnership with community organizations.

Centralized Accountability or Local Flexibility (or both) – Some startup staff expressed concern that undue specification of new work procedures and of performance standards may lead to less local creativity in reaching agreed upon goals. They proposed compromise suggestions, short of total local flexibility in procedures and measures:

> Allowing flexibility on how to achieve ultimate goals, as long as they are consistent with a common vision or set of principles.
>
> Reaching agreement on locally relevant performance measures of ultimate goals.

One, or Many Community Steering Committees – Staff noted that oversight problems were encountered as different initiatives were implemented in the same community.

> The overlap in coordination issues and agency/community staff participating argues for a more common steering committee.

The advantages of focusing on specific sets of families, youth, or people with disabilities and their barriers to services argue for setting up specialized partnership committees.

Co-Locating or Out-Stationing Staff – Physical proximity facilitated client access and working together on common tasks. However, the need to co-locate with different partners for different purposes made decisions problematic on who should co-locate with whom and where.

Three New Service Integration Initiatives

The early experiences of NWD startups were crucial in informing policy makers about the validity of the first steps taken. As Dennis Braddock says: "*We are headed in the right direction. The momentum created by this progress is building. We shouldn't stop, or even slow down.*" (Dennis Braddock speech, May 15, 2003)

The same early experiences also indicated what further steps in service integration some local staff and communities were ready to take, and those new initiatives are already taking place.

The "Coordinated Services Charter" – This initiative, led by the Economic Services Administration and supported by the entire DSHS Cabinet, builds on the experiences of the NWD WorkFirst startups. It ensures that clients receive unduplicated and coordinated services from DSHS agencies, contractors and community partners. The objective is to develop process for integrating services and leveraging resources for clients served by multiple DSHS programs, contracted providers and community partners. Coordinating services provides a single point of access to these services through the case staffing model.

The Coordinated Services Charter goes further than the initial NWD startup requirements. It advocates for earlier screening of multiple needs WorkFirst clients, partnerships with community organizations, and earlier more holistic interventions. It proposes to create for all WorkFirst clients who have multiple needs "*a new way of doing business – a mind set... building a culture of client-centered collaboration.*" (Dennis Braddock speech, May 15, 2003)

The "Family and Communities Together Initiative" – This initiative, led by Economic Services and the Children's Administration together with Juvenile Rehabilitation and Health and Rehabilitation, goes even farther. It proposes to partner in a new egalitarian way with individual communities, seeking to prevent people from becoming DSHS clients, particularly clients with multiple needs. "*I am proposing we change DSHS's relationship with families, neighborhoods and all our community partners.... it's about finding new ways to mobilize all the external resources that support prevention and help our clients.*" (Dennis Braddock speech, May 15, 2003) The details of how to do this will be worked out with two pilot communities in Spokane and Whatcom counties.

The "Medicaid Integration Project" – This initiative, led by the Medical Assistance Administration together with the Aging and Disabilities Services and Health and Rehabilitative Services, breaks new ground in working with the frail elderly and persons with disabilities. It has proposed several new programs. The most significant are:

- a pilot program now headed towards an RFP, which replaces separate long-term care, acute medical care, mental health and chemical dependency treatment systems with a single provider contracted to deliver all of those services at reduced cost to Washington State; and
- a pilot program to link nursing homes residents with physicians who will make house calls to their sites.

These new initiatives moves us further towards the elements of the No Wrong Door long-term design.

Staff Suggestions on Implementation Issues for Next Steps in Service Integration

Development of early screening tools – Local staff feel the need for help from expert central staff in this matter. (This is now happening, in preparation for the implementation of the Families and Communities Together pilots).

Development of communication tools for staff and community partners tracking shared clients, plans and outcomes – Staff developed their own paper or electronic forms, but they are duplicative and inefficient. They are seeking a better common tool. (Two NWD sites are testing collaboration software, called e-Room, to see if it helps to resolve some of these problems).

Procedures for overcoming legal/accounting problems in blending funding or re-allocating cost-savings to finance upfront NWD efforts – Staff seek central authority assistance in "*going through the legal hoops.*"

INTRODUCTION

The Quest for Service Integration

The Department of Social and Health Services (DSHS) was created as an umbrella agency to bring together state human service programs, so that people could get comprehensive assistance with many, often interrelated needs. Efforts were made to co-locate various program offices to make access to services easier.

These efforts were undermined by subsequent trends toward specialization of programs and staff, and separate funding and accountability requirements. This resulted in separate, often uncoordinated service plans for the same client, implemented by multiple case managers from multiple programs. A holistic, customer-centered view was often the victim of specialized eligibility requirements.

Clients with multiple needs faced a maze of eligibility doors. To get the services they needed, clients had to deal with various social/health service providers who had different perspectives and who didn't communicate with each other about the needs of shared clients. Many client needs went unmet because clients couldn't find their way through the maze to the services they needed. In many cases, this led to deeper, more intractable and expensive problems and crises.

No Wrong Door (NWD) Long Term Design

Against the maze of many doors, top DSHS managers, the DSHS Cabinet and DSHS Secretary Dennis Braddock (as well as former Secretary Lyle Quasim) counter-posed the image of "*No Wrong Door*" -- a vision of human services in which clients get fully coordinated, comprehensive services no matter where or how they enter the system.

The No Wrong Door project began in January 2001 by gathering data on clients with multiple needs, information on local initiatives, national expertise, and the advice of experienced, innovative front line staff from various programs. The No Wrong Door design teams, composed of these front line staff, proposed new values, more coordinated practices, and a model of how a holistic, client-centered system could work. For a description of that model and the process of its creation, see the 2001 report by Webster, Longhi, and Kohlenberg.[1]

The long-term design for No Wrong Door included not only better coordination and service integration among different program staff within DSHS, but also teamwork with natural supports (family, friends, community groups) and with community partners (other government agencies, contracted service providers and private community organizations).

---

[1] Webster, C.A., D. Longhi, and L. Kohlenberg. 2001. **No Wrong Door: Designs of Integrated, Client Centered Service Plans for Persons and Families with Multiple Needs**, RDA Report 11.99. This report may be read or printed from the RDA website at: http://www1.dshs.wa.gov/rda/rc/subject%20word/nowrong.htm).

This report summarizes process findings on how the first 'No Wrong Door ' (NWD) startups are faring. The NWD startups were launched in January 2002. This evaluation collected information nine months after NWD projects were started in the first seven localities. It describes initial successes and identifies obstacles and challenges as implementation proceeds statewide.

The summary findings reported here are based on

Observation of the new ways work is being done,

Focus group input from NWD staff participants,

Interviews with key DSHS staff from various program areas, and

Interviews with staff of other agencies and of local community partners.

There are three types of NWD startups:

NWD WorkFirst Startups – Community Service Offices working with long term WorkFirst clients and their families who have multiple barriers to employment.

NWD Troubled Youth Startups – Children's Administration social workers and Juvenile Rehabilitation Administration community counselors working with youth who are coming out of rehabilitation institutions, who are also wards of the state and have multiple needs.

NWD Disability Crises Startups – A-Teams composed of agency supervisors and community partners working with people who have multiple disabilities and who are in crisis or are difficult to serve.

CHAPTER 1: GENERAL FINDINGS

In the following three case studies, the names of clients and details of some of the cases have been changed to protect client confidentiality and location.

Three Case Studies

Juan - By the time he was 16, Juan Thomas had dropped out of school, become a gang member, become addicted to alcohol and drugs, and had been kicked out of his home. After getting in trouble with the law, he served time in one of the Juvenile Rehabilitation Administration (JRA) institutions.

Last year he was scheduled for release from the institution as a ward of the state. He would ordinarily have been placed in a foster home or group care home. He might have run away, as he had done before. He would have been out in the world largely on his own, ill equipped to make the right choices for his life. There was a strong likelihood that he would have gotten back with his old gang buddies and ended up in trouble with the law again.

Busy Children's Administration (CA) social workers and JRA community counselors would have tried to plan and provide some services for Juan, but they would probably have done so separately, starting just before his release, at the time of his release, or weeks later.

Schooling arrangements would have been difficult, and could not have been made until housing was arranged. Housing depends on finding a foster care placement, which cannot be reserved in advance. Some JRA community supervision offices have resorted to providing their own schooling, however temporary, to keep youth busy until a more permanent school arrangement can be found. In the difficult transition to life outside the institution, any violation of parole conditions would have put Juan back in the institution.

As part of a NWD project, however, Juan received a visit from his CA social worker and JRA community counselor months before he was to be released. They worked with him to develop a plan for his future. He said he was good with his hands, and motivated to return to school. He had received help for his drug and alcohol abuse. He thought he had that under control. But he had lost contact with his mother and siblings. Could they help? Juan signed a contract agreeing to the conditions of the plan developed with his input, together with his community counselor and his social worker.

The social worker found Juan's mother before his release. The social worker was able to meet her at her home, arrange better, subsidized housing for her, and start outpatient treatment for her own chemical dependency. Juan's mother was convinced to take her son back. The mother knew that if Juan slipped she could call the team together to figure out what to do.

Juan is now back in school – a different one that he attended before. The school was initially reluctant to keep him. The special education teacher got concerned with his lack of progress, but was reassured that she and Juan could get help from Juan's support team. The team was composed of the CA's social worker, the community counselor, the teacher and Juan's mother.

Juan's support team leader, the CA social worker, got frequent reports about Juan from his community counselor – partly because she shared office space in the community supervision building. The social worker and the community counselors often took breaks together, chatted about their more difficult cases, and problem-solved. They also had monthly meetings with local heads of many different DSHS programs, county service coordinators responsible for contracts with mental health and substance abuse providers, food banks, juvenile prevention programs etc. Both the social worker and the community counselor knew that they could draw on the services of all these agencies and programs to deal with the difficult, multi-problem clients like Juan.

Juan has now turned eighteen. He chose to continue living with his mother and is enrolled in a mechanics program at the community college. He has not relapsed into his old substance abuse habits. He does things with his older brother in the Navy, not with his old gang buddies. He has not been in any more trouble with the law.

Nine short months after the No Wrong Door initiative started, interviews with the various leaders of the program say it allows them to better serve their clients, and they want to expand it. They feel this way despite the fact that budgets are shrinking, and the coordination effort takes more time and effort.

When asked about the secret of their success, the lead No Wrong Door social worker said "*It is a question of earning trust from all the different local community providers that you and the team are not going to drop the ball. You will not simply refer and walk away. They will not be left holding the bag when things fail or get tough. You, the team, will be there… to work together. It is also less lonely to work this way: you can share ideas, and experiences. You know who to call for help when there are problems in getting the right services at the right time.*"

The community counselor said: "*Work is so much easier with these higher risk youth. We don't expect miracles, but it is so much easier to find out stuff, especially with our offices being across from each other. She (the social worker) is one of us.*"

Betty - Time is running out for the 30-ish woman, Betty Kohler, sitting in the local Community Services Office. She has three kids, and has been on TANF for four years – close to her five year lifetime limit for economic assistance – and she's at least twice failed the GED course and been fired from her job as a hotel maid. She's currently failing at her child care job. The case worker does not know what to try next.

This is what the case worker reports in a quick debriefing with a group of people gathered for the case staffing prior to inviting Betty to join in. It is a multi-disciplinary team, this time composed of Betty's case worker, a social worker from the Community Service Office, a Children's Administration social worker, a child support enforcement worker, a Division of Vocational Rehabilitation counselor and an Employment Security Department counselor.

Betty is invited in, accompanied by her case worker. At first she is shy, as all the staff introduce themselves, but as people in the group say they want to help, Betty starts talking. She talks about all her attempts at getting her GED, at getting jobs. Tears form in her eyes. Somebody hands her the box of tissues, reassuring her. As she talks, it becomes evident why she's having so much trouble. She dropped out of school at seventh grade, and has trouble with numbers and reading. She says she's outgoing, likes people and "*looks normal on the outside*." She really tried to do the course work to get her GED. She liked her job at the hotel. It was good work, easy, and her coworkers were nice. Unfortunately, there was an incident, and the hotel management fired everyone who worked a particular section of the hotel.

She struggles with two of her kids, who are in special education classes, but is proud of being able to be a good mother for them. One does not do well in school at all, but he likes sports. She takes him to sporting events. She had trouble with her husband, who mistreated her and her kids, but he is now in jail.

This interview opens up new options for her: she may qualify for a permanent disability (SSI), because of her apparent developmental disability, or she may find work more suitable for her skills and abilities. She is motivated to work, but she needs the right type of job. She is a responsible parent for her children, but may need some more specialized day care.

An appointment is set up for the next day, at a building down the street, with the Vocational Rehabilitation counselor. The counselor gives her directions: she will arrange for a better assessment and go from there. The risk of Betty being on sanction, receiving a reduced WorkFirst grant, is avoided. A further plan will be developed after her assessment. Betty may no longer be bouncing around inside the system.

After the meeting with Betty, the group of social service workers debrief. They wonder whether, had this group case staffing been available at Betty's first sign of failure, this client's probable developmental disability would have been discovered earlier. When asked later, the case worker says: ***"We are so busy, we don't have time to dialog in depth with clients, we didn't catch it: Betty was so outgoing, so normal... With a little more time allowed for staffing this case, we would have saved lots of money... and Betty wouldn't have a string of failed tasks behind her. Others like her often give up, don't show up, don't trust, open up and talk."***

Hattie - Homeless Hattie Smith has an unusual way to find housing. The fifty year old woman gets drunk enough to be admitted to a detoxification center. When offered substance abuse treatment, Hattie refuses. When released, she often just sits in the street close to the center, talking to people. Then she wanders the streets and stops traffic until a police officer picks her up and takes her to jail.

This is not exactly the most cost-efficient way to put a roof over her head. And she is a danger to herself and to motorists. She has been hit by cars at least twice and ended up at the hospital. It costs taxpayers a lot of money to pay for this: hospital beds, detoxification beds and jail beds. And it's been going on for a long time.

The head of the local substance abuse treatment agency reports this at the monthly meeting of local human service agency supervisors in this community: the A-Team. The A-Team includes many supervisory staff and contractors from different DSHS programs areas (Aging and Adult Services, the Division of Developmental Disability, the Division of Vocational Rehabilitation, local Mental Health providers and the Regional Support Network, Alcohol and Substance Abuse treatment agencies) and also representatives of local health agencies, jail and state Department of Corrections managers.

Hattie is perhaps the most notorious case, but there are other people like her. There are no easy answers for Hattie's case, but now, the A-Team community service providers and agency managers can start searching for creative solutions. The possibility of homeless shelters are discounted since they are not appropriate for Hattie. They are likely not take her.

They wonder whether Hattie has had a complete mental health assessment. She may be eligible for public mental health services. She wanders, muttering to herself, walks in the middle of traffic… If this is the case, some kind of Medicaid paid secure placement could be found. People at the meeting take out their cell phones and call to find out whether any mental health assessments have been made. If not, perhaps the next time she ends up in jail a proper assessment can be done. It is often hard to distinguish between the effects of substance abuse and mental health problems; plus services for successfully treating co-occurring disorders are not easily available.

The police representative thinks he knows a relative of Hattie, who may be convinced to intervene on her behalf, maybe could authorize getting help for her. He would pursue this and get back to the mental health provider.

Follow-up will be required. The A-Team would review the situation again at the next meeting. The discussion continues on the opportunity to start a 24 hour diagnostic crisis center, which could temporarily provide secure housing and assess people in similar situations, avoiding detoxification, jail, hospital or other costs. More appropriate referrals to services could then be made. This is referred to the representative of the mental health Regional Support Network to gather more information on benefits and costs of such a solution as they are being implemented in other localities in the state.

In a discussion after the meeting, participants admit that unfortunately there is only so much service providers can do for people like Hattie Smith in the current system. Success of the A-Team cannot be measured by Hattie quitting drinking or getting treatment for her mental health problems. Her chronic condition and her refusal to accept help are major obstacles. However, a cheaper way to put a roof over her head needs to be found, keeping her and others safer.

Achievements: Common Elements of Success

There are common themes running though the stories of Juan, Betty and Hattie. These common themes were identified in meetings and focus groups by staff who worked in the No Wrong Door startups studied for this evaluation. The same themes were reflected in comments of community partners during individual interviews.

Achievement #1: Clients Are Better Off

Better client outcomes are achieved when clients are engaged in planning and goal-setting and services are coordinated.

For people like Juan and Betty and their families, better outcomes flow from their engagement in setting clear goals suited to their priorities and abilities, and a single, comprehensive plan agreed on by all the members of the team involved. The most common staff remark was: "*We are all, finally, on the same page*!"

For people like Hattie, who have multiple disabilities, complex needs, and who are often in crisis or at risk of being harmed or harming themselves or others, a solution to the crisis comes from the coordinated efforts of local leaders. Better, safer, less costly arrangements are found not only for the particular client involved, but for others in similar situations in the same community.

Achievement #2: Staff See the Big Picture, and Their Most Productive Place In It

For clients like Juan and Betty, a set of more appropriate, better, timely services and supports are being provided.

This is happening through:

Better, holistic assessments of clients' needs and issues, across different life domains and staff specialty trainings;

Shared priorities, based on client-centered planning;

More communication across agency staff, leading to more understanding, trust, responsiveness and commitment; and

A larger set of community partners and natural supports to draw on.

Commonly heard comments were: "*We understand more. We have a broader perspective. We feel more supported. Clients can't play games with us: setting us up against each other. It is about time that we get to do this right!*"

For clients like Hattie, a creative solution is often found where none existed before.

This happens through:

Creative problem solving among supervisory staff, meeting as A-Teams, with more knowledge and contacts as a collective group, sharing ideas and, sometimes, resources.

Asked about whether it is worthwhile to do this, since it takes extra time and energy and more funding cuts are anticipated, an almost unanimous response was:

> "*We will continue working this way: it will be even more important to find and coordinate services for these kinds of clients, especially when there will be fewer services to offer.*"

Challenges Experienced by the New Startups

Staff participants in the NWD startups also identified challenges they experienced in implementing service integration. These are the most common:

Clients' Reluctance to Participate

Overcoming clients' reluctance to participate because of distrust and/or non-engagement was identified as a major and common obstacle.

> Staff involved with long term WorkFirst clients say: "*Some clients just don't show up. We write, call, remind them of the importance of the meeting... nothing works.*"
>
> Staff involved with troubled youth and their families say: "*Some youth just don't trust us anymore, they resist opening up and committing...*"
>
> Supervisory staff participating in the A-Team meetings say: "*Some just don't want to be helped... they have dropped out... they are stuck in their ways, however harmful...*"

Suggestions on how to improve the odds of client participation are discussed in later chapters, since they are often unique to the types of clients served

Staff Continuity and Consistent Participation

Getting all the staff from different programs and agencies to attend and work together with continuity was seen as the biggest common challenge.

> "*Not all parties are participating... their expertise is needed*" say WorkFirst workers.
>
> "*Need continuity of staff to make this work... it takes time to learn all the ropes, to gain trust with community partners... turnover means starting all over again*" say Children's Administration social workers and Juvenile Rehabilitation Administration community counselors.
>
> "*Continuity of the same knowledgeable supervisors attending meetings is essential... it takes time to build trust*" say A-Team members.

Constraints in Redirecting Funds

Staff in all NWD startups also cited inflexible funding as a problem, but specific reasons for staff identification of funding inflexibility vary.

> WorkFirst workers suggest that cost savings from better common service plans could pay for the greater up-front staff time it takes to formulate such plans. Currently, there are built-in disincentives for all parties to put in the extra time.
>
> It takes more staff time to orchestrate client-centered interventions with youth that mobilize natural supports and community partners. These efforts often save money. However, the savings gained from less use of alternative state services (like expensive therapeutic foster care and group care) cannot be redirected to pay for this extra staff time.
>
> Cost savings for one agency or program cannot easily fund alternative, less expensive services from another agency or program. Thus, cost effective solutions for some multiply-disabled clients may not be possible due to the under-funding of the less expensive services.

Reflections on the Challenges

The strength of service integration is that it fosters personal relationships, exchange of knowledge, and mutual support between different front line staff and service providers who might otherwise be isolated and frustrated. Staff say they are willing to continue doing this work not only because it is better for the clients, but also because it is better for their own morale. This improvement in job satisfaction may reduce staff turnover, which creates the lack of continuity that is one of the obstacles to success.

However, cost savings don't go to the people who achieve them. Staff say they are willing to continue doing this work, but they may not be able to expand it without additional financial support.

NWD staff believe that client resistance and mistrust could be significantly reduced if NWD integrated screening and services were offered earlier to clients with multiple needs. Clients reached early on would be less likely to have accumulated negative experiences with the 'system' or personal failures. They may be offered help at the right time, early on, when the chances of productive engagement may be highest. This would, however, necessitate an expansion of NWD integrated services to more clients, involving more staff time without additional funding.

CHAPTER 2: THE NO WRONG DOOR DESIGN

No Wrong Door Design Study

In the first six months of 2001, the DSHS Cabinet initiated a study to design better ways to serve clients who received multiple DSHS services. These included services for disabilities, mental illness, substance abuse, child neglect or abuse, long term care for the aged, vocational rehabilitation, economic assistance, and medical assistance.

The DSHS cabinet decided to focus on three major groups of clients who used many of these services:

- ***Long term WorkFirst clients and their families*** who had multiple needs such as developmental disabilities, mental health or chemical dependency issues for one or more members of their family, or child abuse or neglect;
- ***Troubled children, youth and their families*** with complex, multiple needs such as child abuse or neglect problems, developmental disabilities, mental health, or chemical dependency for one or more members of their family; and
- ***People with multiple disabilities*** who often had a combination of aging, developmental disability, mental health and chemical dependency issues.

It was found that a majority of these DSHS clients were also receiving some form of economic and medical assistance. Thus, most often these clients were receiving services from four or more DSHS programs.

As part of the early design, researchers examined how these groups of clients were being served. Their research included focus groups of clients, case histories developed from interviews with front line staff - including case managers and service providers, and meetings with regional managers and regional advisory committees.

The design study then brought together national and local experts and innovators to discuss, with a group of veteran frontline staff drawn from several DSHS programs, better ways of doing things –ways that promised better results.

The group of experienced front line staff was divided into three subgroups of about twelve people, each to focus on one of the three target client groups. For a week, they discussed what was currently being done, and what could be done differently. All three subgroups recommended a similar overall model of better practices.

DSHS executive managers reviewed and approved the essential elements for these better practices:

- *" A **Multidisciplinary Team** composed of appropriate DSHS program staff members, local community organizations, natural supports to the customer/family and the client or advocate when possible to develop an integrated service plan.*

- *A **client-centered integrated service plan** based on the client's strengths, risks, service desires and service needs.*
- ***Cross training** among the multi-disciplinary team to insure a general understanding of each other's services and processes.*
- *A **service broker/coordinator** to coordinate the joint planning and coordinated delivery of services for the customer. (A lead case manager may provide this function.)*
- ***Information technology applications** that are secure and easy to use, to help the team communicate with each other about each shared client.*
- ***Monitoring and evaluation** of the service plan, services and outcomes to allow the team to make model changes, when appropriate.*
- ***Flexible use of funding** among the multi-disciplinary teams to insure that the client receives services for which he/she is eligible.*
- ***Co-location** of the team to make it easier for the shared client to obtain services and to allow the multi-disciplinary team to learn to work together. If co-location was not possible, the out-stationing of some service providers and the nearby office location of others could be tried."*[2]

Top executive managers considered the latter two elements, flexible funding and co-location, as desirable in the long run but probably not achievable in the short run.

See Appendix 1 for a description of No Wrong Door values, a flow chart for coordinated services, and a narrative on ideal models of case coordination in the long run.

Expert teams of DSHS managers then started working to resolve some of the barriers to the implementation of these essential elements. The barriers identified were:

- Lack of a shared consent form to resolve confidentiality restrictions in sharing information in order to jointly plan for and serve shared clients;
- Lack of cross-program knowledge and experience working in multi-disciplinary teams on client-centered plans;
- Lack of computer applications to facilitate communication among multi-disciplinary team members;
- Lack of a common screening tool for multiple need clients/families; and
- Lack of flexible funding within and across DSHS program areas.

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[2] Source: No Wrong Door: Designs of Integrated, Client-Centered Services Plans for Persons and Families with Multiple Disabilities, August 2001, RDA Report 11.99, page 7.

In the short time available (June-July 2001) the expert teams developed a shared consent form, and the DSHS Budget Director recommended a procedure for overcoming some of the barriers to flexible funding – the perceived, but not legally binding, funding restrictions. Computer applications were recommended but were not affordable by January; later two of the pilot sites began evaluating the use of collaboration software which answered some needs.

No Wrong Door Startup Requirements

The next step was to formulate initiatives that would start implementing the designed NWD elements that were doable in the short run. On September 21, 2001, DSHS Secretary Dennis Braddock issued a NWD startup guidance memo. This memo cited the first three NWD elements as minimum requirements for each startup:

- ***"Multi-Disciplinary Teams (MDT)** – the start-up must involve a multi-disciplinary team composed of staff from department divisions who share a mutual client. It may also include case managers from systems outside the department. Be sure to include the tribes as appropriate. The MDT will review the client situation and, in a collaborative way, determine what the best service plan for the client is. These should be ad hoc teams, composed of the client's case managers, not a standing team that reviews many cases. The exception to this requirement will be the AASA A-Team, which is a standing committee.*
- ***Client Involvement** – the start-up must involve the client or his/her representative, where possible, in case direction and decision-making.*
- ***Cross Training** – the start-up must identify ways the divisions will ensure that their staff are aware of the programs and services offered by the other involved divisions."*[3]

The DSHS secretary's memo also required the use of the newly developed consent form and the development of local strategies to overcome some perceived inflexibility in funding:

- ***"Release of Information** – a team of staff from all the divisions has developed the Consent to Exchange Confidential Information for Services Coordination form, DSHS 14-012. It covers all privacy and security contingences for every program. The startup must have a completed form for every client in the project.*
- ***Client Services** - Staff are encouraged to develop creative collaborations between divisions in the delivery of services to mutual clients. Staff sometimes feel hampered by program budget rules from developing the services they believe clients need. They may not be aware that a particular budget guideline can be waived. You should develop a process within your administration for clearing these questions."*[4]

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[3] Source: Dennis Braddock, September 21, 2001 Guidance Memo.
[4] Source: Dennis Braddock, September 21, 2001 Guidance Memo.

Some other long term design elements were not seen as achievable in the short run, so they were not included as initial required elements of NWD startups. See Appendix 2 for the full text of DSHS Secretary's Guidance Memo.

Comparison of Short Term and Long Term Designs

Service Integration Elements

Figure 2.1 illustrates the elements included in the NWD long term design that were required of the NWD startups, and those that were not. The white boxes – with "Y" for "yes", represent elements included. The black shaded boxes – with "N" for "no", represent the elements not included. The light gray shaded boxes with "S" for "Sometimes" represents the elements included in some but not all startup sites.

When comparing the two columns --long term design and startup requirements -- one can visually identify the "Y" elements in both columns. The emphasis of the NWD startups was on:

- Shared clients already receiving multiple services;
- New Multi-Disciplinary teams composed mainly of DSHS staff and DSHS contracted providers;
- Development of better-coordinated plans of services based on better knowledge of client needs and other DSHS programs;
- The new common consent form and better cross training.

Figure 2.1
Comparison Between Design Teams' Long-Term Design and Startup Required Elements for NWD Better Practices

NWD Better Practice Elements	**Long Term Design** (May 2001)	**Startup Requirements*** (September 2001)
Shared Client Definition / Consent		
Receiving multiple services	Y	Y
Common consent form		
Having multiple needs		N
Client Engagement (Needs and Strengths)		
Client / family / advocate participation and voice	Y	S**
Screening tools for multiple needs		N
Planning based on client strengths and problems		
Meetings at time and location convenient to client		
Appropriate Timing (Early / Late Identification & Services)		
When multiple services occur	Y	Y
When multiple needs first arise		N
Appropriate Teams (DSHS, Community, Natural Supports)		
Multi-Disciplinary Teams (MDT)		
Includes different DSHS program areas	Y	Y
Develops an integrated service plan		
Composed of direct client support persons		S**
Includes community partners		N
Includes natural supports for family/customer		
Provides continuum of coordinated services		
Supports appropriate, common client outcomes		
Service Broker / Coordinator (Lead Case Manager)		
To coordinate joint planning	Y	Y
To obtain knowledge of needs		
To coordinate delivery of services		N
To assure needs are met (continuum of care)		
Cross Training (Understanding)		
Each others' services (DSHS programs)	Y	Y
Each others' processes (culture, language)		N
Understanding Client-Centered, Strength Based Approach		
Flexible Use of Funding		
Co-Location		
Continuum of Care (Feedback Loop)		
Technology Application		
Communication about client	Y	S***
Communication with each other		
Team Monitoring		
Of common service plan	Y	Y
Of services provided		N
Of changes of needs and new plans		
Evaluation		
Of startup implementation (process evaluation)	Y	Y
Of program effects (client outcomes)		

Legend

Y	Yes
N	No
S	Sometime

* Startups were for long-term TANF clients, multiple disabled in crisis and youth leaving JRA institutions.

** A-Teams have standing teams of line staff supervisors and no direct client participation.

*** Two startups are piloting a new communication tool: e-Room

Looking at the dark shaded boxes, one can see the NWD long term elements that were missing from the startup requirements. The crucial elements of the NWD long-term design that were postponed were:

- Early identification and screening of multiple needs when they first arise, which would have involved the development of prevention and early intervention practices and services.
- A broader inclusion of natural supports, other agency and community partners that would have required greater efforts and time spent in community partnering.
- A more customer- and community-driven, strength based, holistic definition of desired outcomes that would have required require more cultural change and staff training.
- The use of appropriate screening, communication and data sharing tools that would have required the development of new tools.
- An increase in flexibility in funding that would have required new administrative policies or waivers.
- More co-location or out-stationing of staff that would require logistical long term planning.

Outcomes

Outcome priorities for the start-ups were focused in practical areas where client life improvements also supported DSHS program goals:

For long term WorkFirst clients:

- Helping them cope with multiple issues in their lives
- Getting them employed sooner.

For state-dependent youth coming out of rehabilitation institutions:

- Helping them get more family and community support
- Reducing further criminal recidivism
- Reducing placements in costly foster care and group care facilities.

For people with multiple disabilities experiencing crises:

- Finding creative new ways to keep them healthier and safer
- Reducing more costly crisis interventions.

Targeted Shared Clients

The focus for the startups was on a subset of shared DSHS clients, who were deemed difficult and costly to serve separately.

- WorkFirst startups focused on long term clients –those who had received services for three years or more, and were at risk of losing economic assistance after their fifth year.
- Children and family startups focused on a small subset of very high-risk youth: those leaving Juvenile Rehabilitation institutions who were still wards of the state. Startups did not tackle trying to implement more integrated service practices for all multiple-needs troubled children, youth and their families, where families are getting services from different parts of the agency.
- Multiple disability startups focused on people in crisis. Not all people with multiple disabilities would get jointly coordinated, integrated services.

NWD Startups and long term service integration

DSHS implemented seven NWD initiatives in January 2002, soon after their design. They were not to be simply experimental pilots. From the outset, DSHS Secretary Dennis Braddock made clear that these initiatives were to be implemented alongside current practices, aimed to spread progressively statewide. Some were expected to go statewide within a period of two years.

Furthermore, missing NWD elements were not ignored. In April 2002, at the direction of Secretary Braddock, work began on piloting a new computer application facilitating sharing information across DSHS programs. Two NWD startups volunteered to test the collaboration software called "e-Room." The purpose was to learn about what tools would be most useful and most used by staff as service integration progressed.

At the same time, the need for the development of new intake and screening procedures was recognized. Planning for this was postponed until more experience was gained by the startups.

Finally, an evaluation was planned for the NWD startups. The purpose was to learn about No Wrong Door achievements and challenges in different settings and with different clients. Prompt feedback of results to local NWD coordinators, to statewide NWD coordinators and to the DSHS Cabinet would enable:

- Better implementation,
- More informed development of new service integration initiatives, and
- Formulation of further service integration steps for existing startups.

CHAPTER 3: NEW WORKFIRST STARTUPS

Experiences of Community Service Offices (CSOs) Working with Long Term WorkFirst Clients

In January, 2002 NWD WorkFirst startups were launched in Community Service Offices in Puyallup, Seattle and Spokane. Each site developed different ways of adapting the key NWD elements required. All CSOs statewide are expected to start implementing service integration initiatives by the end of 2003.

The following description of the NWD implementations are based on visits, observation, focus groups and interviews with key participants in the three original startup localities and in Bellingham.

These startups were originally designed to provide integrated services to long term WorkFirst clients with multiple barriers to employment. 'Long term' was initially defined as those on economic assistance for 36 months or more. There was a sense of urgency about this group of clients because, given the five-year lifetime limit on economic assistance, they were eligible for only two more years of assistance.

Puyallup CSO- Before NWD, as part of WorkFirst, staff at this CSO had already accumulated experience in collaboration by working with Employment Security Department (ESD) staff co-located in the CSO. "*Clients could not tell who they were talking to: ESD or DSHS staff. We work as a team, we share the same type 'cubicles'.*

Having a part-time chemical dependency counselor out-stationed at the CSO has also promoted the ideal of integrated service delivery. CSO staff say: "*We can always ask him for advice... when we need to.*" The same applies to a psychologist, on a fee-for-service contract, who works part time at the CSO; to a nurse who provides family planning services; and to a domestic violence counselor. Furthermore, the social workers specializing in eligibility for permanent disability assistance (SSI) have some in-house expertise in health and disability issues.

At the invitation of a forceful, innovative NWD coordinator, staff from other DSHS programs agreed to co-locate for a day each week at the CSO. Some office space and laptop computer connections were provided for those staff. They were also asked to participate in the new NWD case staffings, as members of a standing Multi-Disciplinary Team (MDT). This team meets weekly to review difficult cases. At a typical weekly meeting, they would review about 6 cases, for a total of about 280 per year.

For each meeting, the Work First supervisor selected the WorkFirst clients whose cases needed to be reviewed by the MDT team. They were long term clients, on assistance for 30 months or more, who received services from multiple DSHS programs. The DSHS Client Registry (a database identifying the DSHS offices and programs serving each DSHS client) was used to identify the clients who were being multiply served, a letter was sent inviting the clients to the meeting, along with the release of information form that had to be signed so that programs could share information about the client. Sometimes, follow up phone calls were made as reminders.

Before the meeting, information was sent to agency participants about which clients were to be reviewed, so that team members could review their records prior to the meeting. The team would meet prior to the client's appointment time "*to triage the case and to develop direction for the activities of the case staffing.*" This was done regardless of whether the client showed up for the appointment.

When a client arrived, he or she was briefed on what to expect, and introduced to the MDT team by his/her case worker. Team members were unlikely to be known by the clients, except for their CSO case worker, and maybe the CSO social worker and Employment Security staff. Most clients would not have met the team members from Child Support Enforcement, the Division of Vocational Rehabilitation, the Children's Administration, the Division of Alcohol and Substance Abuse or others.

The client would be told that they were all there to help plan services or supports. As clients talked about their difficult experiences dealing with many issues, staff found that they would get emotional and tears were likely. "*We started having a box of Kleenex handy.*" Cookies and coffee would also be available to make the meeting less formal and intimidating, and clients took advantage of them as they became more comfortable with the team.

At the conclusion of the meeting, a plan of action would be developed and entered into the CSO management information system. A computer on a side of the conference room was available for this purpose. The CSO case worker would be responsible for follow up on the plan.

Spokane Valley CSO - The idea of creating a single, client-centered plan for coordinated services was familiar to all the case managers and social workers interviewed in this CSO. They had attended training on "wraparound" approaches or on "ITC" - Individual and Tailored Care. They pointed to the directory of community partners on their cubicle shelf, with descriptions of services and contact information for staff. It is updated annually by a local community college and available by mail or at the nearby bookstore.

The CSO staff welcomed the NWD implementation as simply an extension, or validation, of what they were already doing. Ad-hoc multi-disciplinary teams, particular to the needs of specific, complex clients, had been meeting already for a year or two. This CSO decided to formalize and report for the NWD initiative the team meetings they held for WorkFirst clients with multiple needs who had been on assistance longer than 36 months. They expected to meet with approximately 200-300 such clients during a given year.

The team meetings were convened by the case worker or social worker involved with the client. Sometimes, in special cases, the WorkFirst supervisor or social work supervisor also attended. Meetings were held in various meeting rooms at the CSO or at other agency or community partners' locations. One CSO case worker said she had participated often as a member of team meetings at a community partner's building in a shopping center close to downtown.

The team meetings were held at whatever times they were convenient to the clients and the team members involved. They pointed to a fat white scheduling book: coordinating and scheduling rooms and staff was not easy!

Some staff from other agencies were co-located at the CSO: a community college staff, a family planning nurse, a part-time chemical dependency counselor, and the Employment Security staff assigned to WorkFirst. They would all participate at team meetings when necessary. Staff from other agencies or community partners were invited to meetings when they were already involved with a client, or when their services would help a client.

The new release of information form was considered useful. They had started using it for all multiple-needs clients.

Client Registry, the electronic database indicating past access to different DSHS programs, was used to identify clients who were receiving multiple services across the agency. However, the DSHS Client Registry could not identify clients who had multiple unmet needs for DSHS services.

For identifying unmet service needs at an earlier point in the client's service history, short, initial screening tools were needed. These had to be briefer than the various full assessments for each expressed or suspected need. Few questions about various types of needs were asked at first intake, but they could be improved, staff said. Furthermore, clients only admitted to certain kinds of needs as they became more familiar with CSO staff and trusted them with more sensitive information at later meetings. Improved initial screenings could be made at those times as well.

Some staff said that shorter, intermediate level , screening tools would also be helpful. For example, it took too much time to go through a full chemical dependency assessment for all clients referred as having substance abuse problems on the basis of a few questions at intake. Already, the chemical dependency counselor out-stationed at the CSO and other staff at the ADATSA assessment office had started developing a shorter version of the full assessment as an intermediate screening tool. They were planning to use it to screen the extent of substance abuse problems, before a full assessment was conducted.

Seattle/Rainer CSO - This CSO implemented the NWD initiative with a combination of features found in Puyallup and Spokane Valley.

The following practices were similar to the Puyallup startup:

- One NWD coordinator called all the team meetings, attended and led them;
- Meetings were all held at the CSO at set times;
- Only clients on assistance for more than 36 months had multi-disciplinary team meetings;
- Client Registry was used to identify NWD clients;
- The Release of Information form was used primarily for NWD clients;
- At each meeting a prior discussion occurred among team members before the client was invited to participate.

As at the Puyallup CSO, the Seattle/Rainer CSO was expecting to conduct such meetings with about 300 clients yearly.

The following practices were similar to the Spokane Valley startup:

- The composition of the teams depended on what services the clients were receiving, with the exception of the NWD coordinator, who led all team meetings;
- Community partners, in addition to other DSHS program staff, often attended if they were involved in the services provided to the particular client.

This is a more centralized approach, with set times for team meetings, a central coordinator, and more standard procedures. However, this was paired with a more decentralized component: varied composition of multidisciplinary team participants depending on the client's set of needs/services.

Seattle/Rainer, like the Puyallup startup, held these multidisciplinary team meetings only for those on assistance longer than 36 months.

Again, as in the other startups, some other agency and provider staff were co-located: Employment Security, a contracted psychologist, a part time chemical dependency counselor, and a family planning nurse.

Achievements

A summary of achievements and challenges is presented in Figures 3.1 and 3.2. These were obtained from focus group discussions with multidisciplinary team members in the three CSOs and from individual follow-up interviews.

Only summary findings are presented across all the three NWD WorkFirst startups. Strikingly similar elements were obtained from each of the startups. There were, however, differences in degree of successes or degree of difficulty in overcoming barriers. These are discussed in a later section of this chapter.

Common to all of the above startups, to different degrees, were the following successes:

For System of Care - The multidisciplinary team members agreed that working together was better, since it led to:

- More knowledge of overall needs: "*all on the same page*;"
- More holistic way of planning: " *broader perspective on issues*;"
- Closer coordination of services: " *balanced resolution of issues*."

For Clients - Clients were better off, multidisciplinary team members thought, since customers now:

- Had more of a voice: "*talked about their issues and problems*;"
- Concentrated more on achievable outcomes: "*focus on solid goals*;"
- Received more appropriate planned support and help: "*fix life problems so can get job*."

For Client/Staff Relations - Client-centered interaction between team members and clients was crucial to the degree of success at each point:

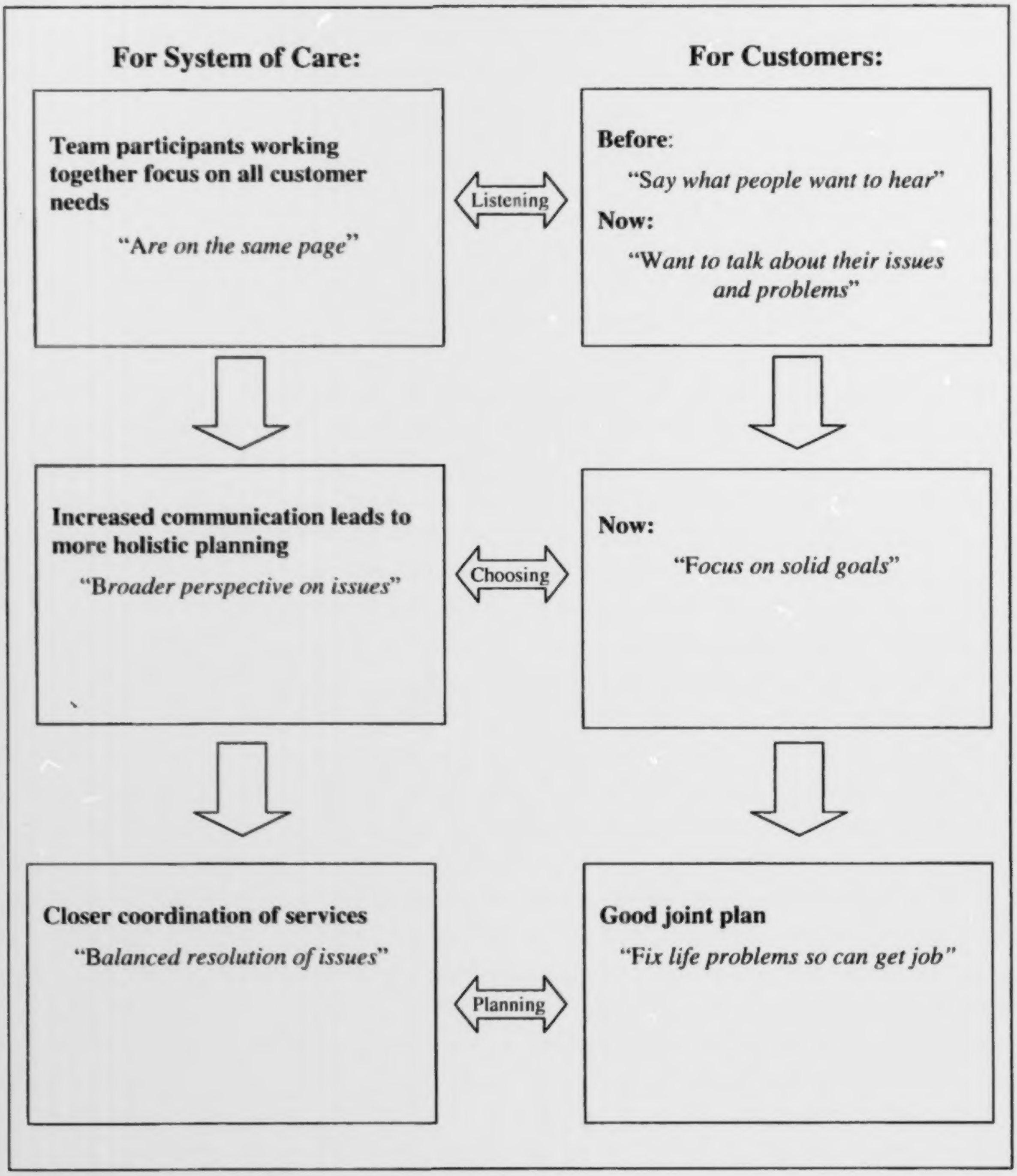
- Listening to each other, staff and clients,
- Choosing goals together, and
- Planning services and supports to resolve issues together.

In the eyes of the participants of the startups, these are important achievements. Staff involved expressed enthusiasm for this approach, because it was better for clients, and because it engendered mutual support and greater job satisfaction among staff.

Statements about successes are not simply self-congratulatory judgments from CSO staff. Interviews with other partners involved – Employment Security Department staff working in the CSOs, contracted providers such as chemical dependency counselors and psychologists, and DSHS staff from other administrations – also revealed appreciation and support for this work. Most of these partners were glad to come to the table and participate. According to these more unbiased sources, the NWD approach has great promise for greater productivity and job satisfaction for staff and better outcomes for clients.

Figure 3.1

Achievements of NWD WorkFirst Startups



For System of Care:

Team participants working together focus on all customer needs

"*Are on the same page*"

Increased communication leads to more holistic planning

"*Broader perspective on issues*"

Closer coordination of services

"*Balanced resolution of issues*"

For Customers:

Before:

"*Say what people want to hear*"

Now:

"*Want to talk about their issues and problems*"

Now:

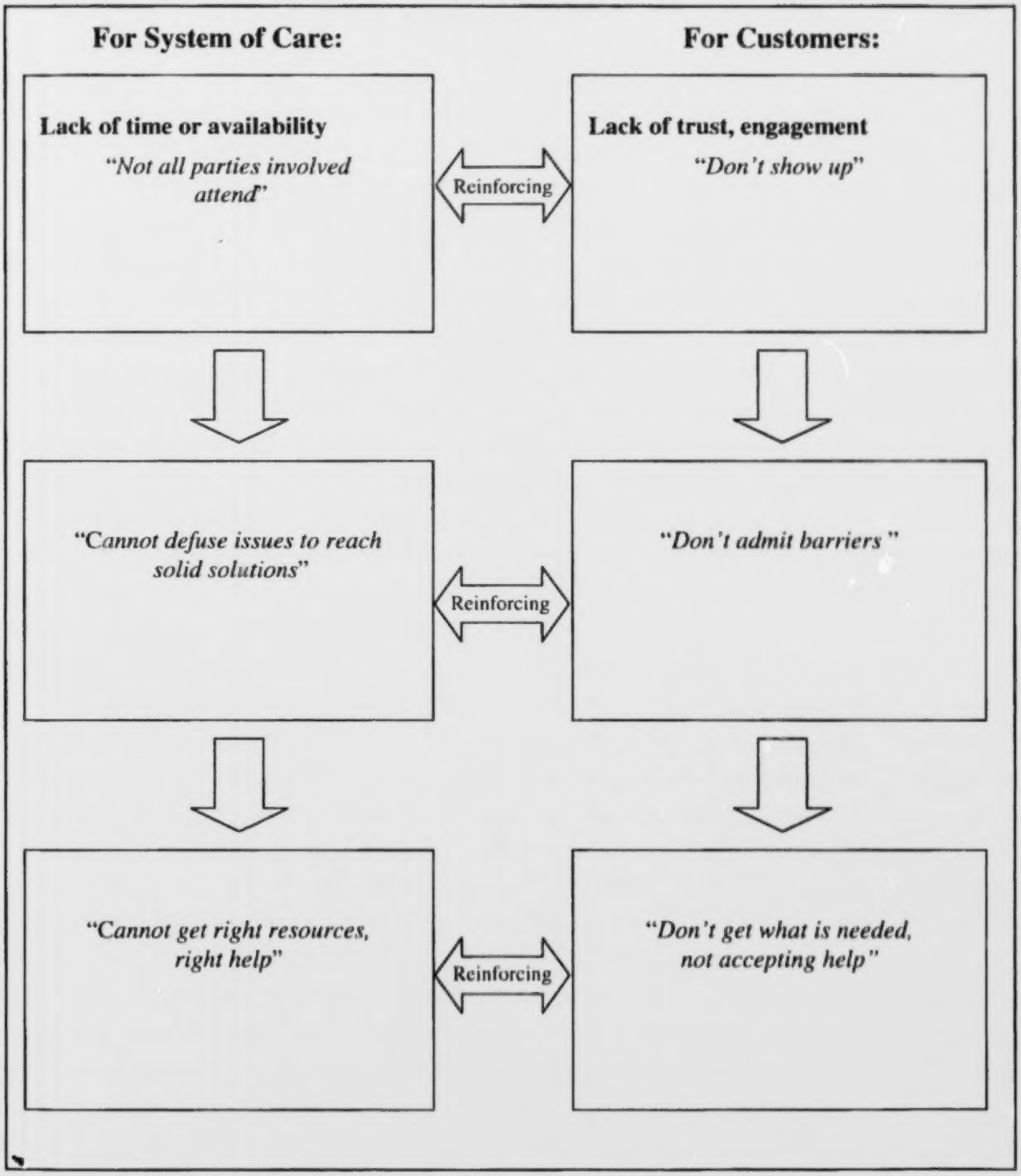
"*Focus on solid goals*"

Good joint plan

"*Fix life problems so can get job*"

Figure 3.2

Challenges of NWD WorkFirst Startups


For System of Care:
For Customers:
Lack of time or availability
"Not all parties involved attend"
Reinforcing
Lack of trust, engagement
"Don't show up"
"Cannot defuse issues to reach solid solutions"
Reinforcing
"Don't admit barriers"
"Cannot get right resources, right help"
Reinforcing
"Don't get what is needed, not accepting help"

Challenges

The following challenges were similar in all three startups, but the degree of specific challenges varied among the CSOs:

For System of Care - The multidisciplinary team members identified the barriers to working together as

- Lack of time or availability of staff " *not all parties involved attend*;"
- Partial views represented and a lack of communication that impede "*defusing issues to reach solid solutions*;"
- Lack of resources or flexibility to get "*the right help*."

For Clients - Client barriers to be overcome were identified as

- Lack of trust and/or engagement so "*don't show up*;"
- Denial or lack of openness so "*don't admit issues/barriers*;"
- Wrong plan or lack of commitment to the right plan so "*don't get what is needed*."

For Clients – System Interactions - Barriers in the system of care interact with client barriers, one reinforcing the other:

- Lack of staff interest or time reinforce clients' lack of trust and vice versa. Conversely, lack of client engagement decreases staff motivation and investment of time;
- Partial view of problems by staff does not help the client admit the presence or salience of other problems, and at the same time, client denial reinforces the partial view of staff;
- Lack of the right help reinforces clients' tendency to not accept help in general, and non-acceptance by the client decreases staff motivation to seek the right help.

These were perceived as difficult barriers. Some are perceived to be partially inherent in the population being served. Staff felt that some of these barriers could be confronted and diminished, and some could be overcome.

Confronting and Reducing Barriers to Success

Client Attendance

There were large differences in the proportion of clients who kept their appointments for NWD case staffings with multidisciplinary team members.

- The client attendance rate was 42% in the Puyallup CSO (measured by CSO staff), about 75 % in the Spokane Valley CSO (estimated by CSO staff), and 50-60% in the Seattle/Rainer CSO (estimated by CSO staff).

All these attendance rates may be remarkably high, given that the clients served by NWD are people with multiple needs and issues and a long history of being on economic assistance. This history often includes repeated failure to get a job and/or non-compliance with service plans. The perception is that only about 10-20% of a comparison group of similar clients would show up to a more ordinary case CSO staffing. These would be staffings conducted in a CSO which was not a NWD startup, without the participation of other DSHS program staff or contracted providers, with clients in the fourth or fifth year of assistance.

However, the differences in degree of reported attendance among startups, if accurate, are great as well. The speculation among NWD staff is that the differences may be due to two interconnected causes:

- Clients would be more encouraged to attend if the meeting was scheduled when an issue or problem arose in their lives, and at a time of their convenience.
- Clients would be more encouraged to attend if they were to meet with the people who would be providing services to them. This would be more likely if problems and issues were identified early and services needed to solve them were provided promptly.

In essence, there is consensus among staff that if clients see a team of known staff as helping them solve problems promptly, rather than waiting until the client has been on economic assistance for several years, and has experienced repeated personal failures, clients would be more likely to attend and become engaged. Staff readily warn that this is not to say that a 100% engagement rate is possible, given the often serious, chronic, multiple issues these clients have to deal with.

One of the emphases in the new Economic Services Administration plan is to focus on identifying and removing the barriers to client's economic self-sufficiency as early as possible.

Staff Participation at Multidisciplinary Team Meetings

There were also differences in the degree to which staff in different DSHS program areas participated in the multidisciplinary team meetings.

- It is perceived that staff are more likely to meet as part of a multidisciplinary team if they are dealing with their own clients, on their own 'turf'.

The Spokane Valley and Seattle/Rainer CSOs did not report having many problems with DSHS program staff attending - when multidisciplinary meetings were specific to the client, rather than a standing permanent team as in the Puyallup CSO. The Spokane Valley CSO had also met in locations other than the CSO, when appropriate, so location may have been a factor.

One of the emphases in the new Economic Services Administration plan is that in each CSO, a NWD steering committee should be created, and meetings should be attended by other DSHS program supervisors and community agency leaders.

This collective leadership may help resolve practical barriers to multidisciplinary team attendance by all parties.

Attainment of Broader, Holistic, Client Centered Perspectives

- Staff in the Spokane Valley CSO emphasized the important role of 'cultural change' and of staff training in alternative, client-centered ways of serving multiple need clients . They saw this as a prerequisite for the implementation of NWD practices.
- Staff in the Puyallup CSO emphasized the important role of co-location in fostering teamwork and creating a client-centered approach.

One of the emphases in the new Economic Services Administration plan is that *"a comprehensive and holistic delivery culture"* be created.

Whether this can be accomplished by co-location or special training efforts, or a combination of both, is not clear. These evaluation findings identify both factors as important.

Getting The Right Help

- Staff had concerns about specific DSHS programs that were not "pulling their weight," not participating in the multidisciplinary meetings. Often cited were the staff from the Children's Administration and the providers contracted by Mental Health's Regional Support Networks.
- None of the NWD startups at the various CSOs were required to develop community partners.

  The Spokane Valley CSO, however, was embedded in a community where a network of community partners were very actively collaborating before NWD was implemented. The Bellingham CSO, which was also visited during this evaluation, indicated a rather substantial effort at recruiting, co-locating, and sometimes contracting with other community agencies. Staff concerns here seemed to be fewer regarding "getting the right help."

One of the emphases in the new Economic Services Administration plan is to develop better relationships with community partners, planning with them, leveraging resources, and not duplicating efforts.

Future Directions

This effort, which involves all the CSOs in the state, is now called the "Coordinated Services Initiative." This name change reflects changes in program design made as a result of the feedback from this evaluation and the experiences of the NWD startups. The Economic Services Administration has chosen to:

- Identify and resolve issues of multiple-needs clients as early as possible (not waiting till the 30th or 36th month on economic assistance), and provide a single point of access to holistic, client-based services to these clients.
- Develop better relationships with community partners, plan with them, leverage resources, and avoid duplicating efforts.
- Promote internal cultural change that fosters comprehensive and holistic service delivery. CSO leadership and an oversight committee composed of staff from various DSHS programs and community partners will coordinate this effort. This will go beyond the earlier NWD startups in emphasizing not only cross training about different DSHS programs but also encouraging a "*comprehensive and holistic service delivery culture that incorporates positive and ongoing communication between clients and staff.*"

The following are the service integration vision, philosophy, and goals proposed by the Economic Service Administration (ESA) in their newly signed Coordinated Services Charter. They give an indication of future directions in service integration efforts for WorkFirst clients as ESA learned lessons from the experiences of the first NWD startups and moves to statewide implementation.

Vision

"Coordinated Services is a part of the Department's Integration Initiative to ensure that client's receive unduplicated and coordinated services from DSHS agencies, contractors and community partners. The vision of the coordinated services approach to service delivery is to develop a systematic approach to providing holistic services to clients being served by multiple DSHS administrations, community partners, and contractors, and to provide a single point of access to these services through the case staffing model."[5]

Philosophy

"Service integration is key to producing better outcomes for clients and staff. Utilizing a coordinated service approach to service delivery will promote an integrated model that is a way of doing business and not simply a mechanical program. This philosophy supports and encourages a comprehensive and holistic service delivery culture that incorporates positive and ongoing communication between clients and staff."

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[5] Source: "Coordinated Services Charter", May 2003.

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Goals

- *"Leverage and maximize client, family, and community resources to identify client issues earlier and resolve sooner;*
- *Support clients through coordinated appointments;*
- *Develop a coordinated and collaborative success plan;*
- *Deliver a unified Department message;*
- *Increase Department and community communication;*
- *Develop better community partnerships; and*
- *Support staff in their efforts to support our clients."*

See Appendix 3 for the full text of the Coordinated Services Charter.

Summary: Design Elements Implemented and Proposed

Figure 3.3 shows graphically how the service integration elements differed among the three NWD WorkFirst startups.

Figure 3.3
Comparison Between NWD Initial Plans, Achievements and New Initiative Goals for WorkFirst Family Services

NWD Initial Plans		Achievements			Goals
NWD Better Practice Elements in Long-Term Design May 2001	***Startup Requirements*** *Sept. 2001*	**WorkFirst Startups 2002** Puy.	Sea.	Spo.	**Coord. Services Initiative** *April 2003*
Shared Client Definition / Consent					
Receiving multiple services	Y	Y	Y	Y	Y
Common consent form					
Having multiple needs	N	N	N	S	
Client Engagement (Needs and Strengths)					
Client / family / advocate participation and voice	Y	S	S	Y	Y
Screening tools for multiple needs	N	N	N	S	?
Planning based on client strengths and problems					
Meetings at time and location convenient to client					
Appropriate Timing (Early / Late Identification & Services)					
When multiple services occur	Y	Y	Y	Y	Y
When multiple needs first arise	N	N	N	S	
Appropriate Teams (DSHS, Community, Natural Supports)					
Multi-Disciplinary Teams (MDT)					
Includes different DSHS program areas	Y	Y	Y	Y	Y
Develops an integrated service plan					
Composed of direct client support persons		S	S		?
Includes community partners	N	N	N	N	Y
Includes natural supports for family/customer					?
Provides continuum of coordinated services			S	Y	Y
Supports appropriate, common client outcomes				S	
Service Broker / Coordinator (Lead Case Manager)					
To coordinate joint planning	Y	Y	Y	Y	Y
To obtain knowledge of needs		S	S	S	
To coordinate delivery of services	N	N	N		?
To assure needs are met (continuum of care)					
Cross Training (Understanding)					
Each others services (DSHS programs)	Y	Y	Y	Y	Y
Each other processes (culture, language)	N	S			
Understanding Client-Centered, Strength Based Approach		N	N	S	?
Flexible Use of Funding				N	
Co-Location		Y	S	S	
Continuum of Care (Feedback Loop)					
Technology Application					
Communication about client	S*	S*	N	N	?
Communication with each other					
Team Monitoring					
Of common service plan	Y	Y	Y	Y	Y
Of services provided	N	N	N	S	
Of changes of needs and new plans					?
Evaluation					
Of startup implementation (process evaluation)	Y	Y	Y	Y	Y
Of program effects (client outcomes)					

* One WorkFirst Startup (A) is piloting a new communication tool: e-Room

Legend

Y	Yes
▨	No
S	Sometime
?	Unclear

The main differences between the startups, displayed in Figure 3.3, are:

- Puyallup followed closely the NWD startup requirements. It exceeded the requirements in co-location, encouraging other DSHS staff to become out-stationed in the CSO for one day every two weeks.
- Spokane Valley went beyond most of the NWD startup requirements and implemented more of the long term design. The exceptions are co-location and flexible funding strategies.
- Seattle/Rainer implemented all the NWD startup requirements, and a few of the long term design elements.

A comparison of the long term design elements with those in the Coordinated Services vision, philosophy and goals shows that almost all long term NWD design elements are included explicitly in the description of the Coordinated Services Initiative.

CHAPTER 4: NWD TROUBLED YOUTH STARTUPS

NWD projects in Seattle and Yakima were started to improve services to youth released from Juvenile Rehabilitation (JRA) institutions who were dependents of the state served by the Children's Administration (CA). When they are released from JRA institutions, these young people are served by community counselors from JRA, and by CA child welfare workers, who are responsible for placing them in foster homes or group homes.

The intent of these projects was to find better ways to coordinate services between the two DSHS programs in their efforts to reintegrate youth in their communities. All the youth needed a place to live. Most of the youth had problems with schools, and needed an education plan. Most also had mental health and/or chemical dependency issues, and needed continued help to obtain ongoing treatment, medications and other supports.

Two Different Approaches

One of the projects was administered by the Children's Administration (CA), and the other by the Juvenile Rehabilitation Administration (JRA). Two very different approaches were taken. These projects are referred to as the Yakima Startup and Seattle Startup.

Yakima Startup – Two NWD staff were identified to work as partners with youth: a child welfare worker and a community counselor. They were co-located in the same JRA building. The child welfare worker maintained her own office at Children's and Family Services, but was out-stationed at the JRA building.

These two staff both worked half time to devise a better way of serving youth, using a 'wraparound' model that involved:

- Engaging the youth in planning his or her future,
- Exploring the youth's strengths and needs,
- Finding an appropriate team of supportive persons - DSHS staff, community partners, and natural supports such as relatives, teachers etc.,
- Identifying specific goals together with the youth and his/her team,
- Planning services and needed supports,
- Monitoring the attainment of the planned goals, the provision of services, and the resolution of probable crises and changes in plans.

This work started while the youth was in the institution, possibly long before his/her release, in order to provide for some certainty in the youth's plans for the future.

The youth signed a NWD service contract invented by this NWD startup: a simple statement affirming the youth's commitment to participate at team meetings, receive services and work on agreed-upon plans. The youth also signed the release of information form that allowed agencies and community partners on the youth's team to share information about the youth, the goals of the plan, and the services.

Upon release from JRA, the youth's support team met to review the goals and the plan. Teams differed in their composition, but they were all multi-disciplinary, with different expertise and representing different service programs. Some had only paid staff from state agencies and community service providers. Others included family members, teachers and other persons committed to supporting the youth.

NWD services, including various team meetings, continued for up to six months after the youth's release. During this time, the youth's support team was called upon to meet as needed.

In this community, all youth leaving JRA institutions who were dependents of the state qualified for this NWD initiative, starting in January, 2002. Almost all had mental health and/or substance abuse issues. All were at high risk of getting in trouble with the law again. It was estimated that 25-30 youth would be served in a given year by this NWD startup.

Information on whether the youth involved were wards of the state, what particular CA and JRA services they had received, and whether they had received institutional mental health and substance abuse screening or treatment, was obtained from JRA and CA service records. The DSHS Client Registry was not used to identify clients to be served, since staff felt all the needed information could be found in the JRA and CA records.

This NWD startup formed a steering committee composed of managers or supervisors of all state human services agencies involved in the community, plus key leaders of partner community organizations. This committee served as a way for agencies to work together to:

- Provide access to needed services,
- Oversee the work of the NWD staff, together with their DSHS program supervisors,
- Monitor overall progress of the startup,
- Resolve possible problems, and
- Institutionalize this new way of doing business.

The steering committee met monthly to exchange news, solve problems, and make plans. This was deemed to be a startup, which would continue and expand - not a pilot, with experimental, temporary status.

The outcomes sought for these youth included:

- Better reintegration into the community - in school, with relatives, and with peers, not with old problematic friends, gang members etc.,
- Better placement/housing, social, school, and health supports, and
- Less risk of future criminal justice recidivism.

Steering committee members hoped that this work would generate cost offsets by avoiding future criminal justice costs and more expensive state agency services such as therapeutic foster care or group care.

Achievements

Figure 4.1 presents what NWD staff in the Yakima Startup considered their major achievements. Steering committee members identified these successes in a structured focus group discussion. Front line staff, including the NWD child welfare worker and the community counselor were also present, together with their supervisors. The focus group conclusions were confirmed by follow-up interviews with key agency and community staff.

For System of Care

Three key elements were identified as crucial to improving the way the system of care worked for these youth:

- All agencies had reached common goals, commitments and accountability practices regarding working with these youth. This was achieved mainly through the standing steering committee composed of staff from all these agencies, and also through the leadership of the front line staff assigned to this NWD project. This made for a common front. As staff said: *"These youth cannot split us or play games with us any more."*
- The NWD teams formed for each youth became strong advocates for their clients. The community agencies felt that if they helped with these high-risk youth *"they had support, they would not be left hanging."*
- Community partners responded by trusting more that this was a worthwhile effort, not wasting scarce community resources. They said: *"this DSHS effort was credible."* They made more resources available. NWD staff said: *"We got more trust and more resources from the community."*

For Youth

For the youth themselves, three important changes made a difference:

- Youth got quicker help: *"Immediate needs were met fast."* This meant that youth who had long distrusted all authorities, including state and community agency staff, were reassured that what was promised was going to be delivered. They got prompt evidence that they could trust their team members and engage in the process without being let down.
- Youth's voice, their desires, were being heard, so that they could work on their strengths to reach their goals, not what the system made them do regardless of their needs and wants. Staff said that, now, the youth could *"pursue their plan, their goals."*
- Youth were able to get help through their NWD teams. They did not have to go and ask, and wait, for help from different people, and they did not have to tell their stories many times. Staff said: *"They got seamless supports and services through their teams."*

Further observations and interviews, revealed the importance of the NWD Children's Administration child welfare worker, who served as the leader of many of the youths' multidisciplinary support teams, in achieving better outcomes.

- She had to have the skills – often cultural and language skills, as well as personal skills, to engage the youth.
- She had to network with relatives and the community to bring together the appropriate team for each youth.
- She had to maintain good relations with all the community providers in order to guarantee ready access to needed services.

Accountability to the NWD steering committee as a whole, rather than to a DSHS supervisor alone, provided both incentives and recognition for success in these multiple roles and tasks.

Co-location of her office with JRA also helped, since corridor conversations and interactions during breaks and at informal meetings contributed to better communication, trust, problem solving and monitoring.

These conclusions were reached during a three day visit that included shadowing the NWD child welfare worker, and interviews and encounters with other NWD staff, community counselors, a school teacher, a foster care provider and other agency and community.

Challenges

For System of Care

Three main system challenges were identified (see Figure 4.2):

- **The need for continuity of NWD front line staff.** All supervisory staff agreed that "continuity, time and training" for the NWD youth team leaders were essential. One of the two NWD front line positions experienced two staff changes in the first 10 months. This was quite disruptive: it meant that one of the NWD partner consumed a lot of time for training the newer partner, twice, in doing this kind of work.
- **Lack of financial resources to sustain initial team work.** The NWD upfront, intensive work is expensive in staff time. Steering committee staff indicated that there seemed to be no way to continue dedicating the full amount of staff time required, unless a way was found to redirect cost savings obtained. For the first six months of the startup, through extra DSHS funding, the two NWD front line staff were full time. After that staff worked only half time on NWD tasks.
- **Low impact of the NWD youth startup on the community as a whole and on all 'high risk' youth in the community.** If NWD continues to use current, very narrow eligibility criteria for youth to participate, many youth who could benefit from this service approach would be left out, and an important opportunity for earlier intervention and prevention would be missed. More community support and different sources of funding may be available if NWD could expand the number of youth served successfully in this way.

For Youth

Three major barriers confronted the youth (see Figure 4.2 again):

- **Youth initial reluctance to trust, engage and accept NWD services.** This barrier would be less formidable if youth were reached even earlier, months before their release from JRA institutions, and, if possible, even before they commit the crimes that get them sent to JRA institutions.
- **Existing resources for high risk youth were felt to be limited and actually shrinking.** Appropriate foster care providers and mental health services were always scarce. Special school programs were limited. This is a barrier to integrated services. Other funding sources and other agency and community resources need to be explored.

A strategy was adopted to minimize the impact of lack of resources. NWD staff felt that meeting youths' expectations was very important. The fulfillment of this expectation — not just sometimes but all the time – was crucial to building youths' trust in the system. It was also a requisite for better youth outcomes. NWD staff said: "*We never promise anything we cannot provide. These youth have been let down too many times.*"

Figure 4.1

Achievements of NWD Youth Yakima Startup

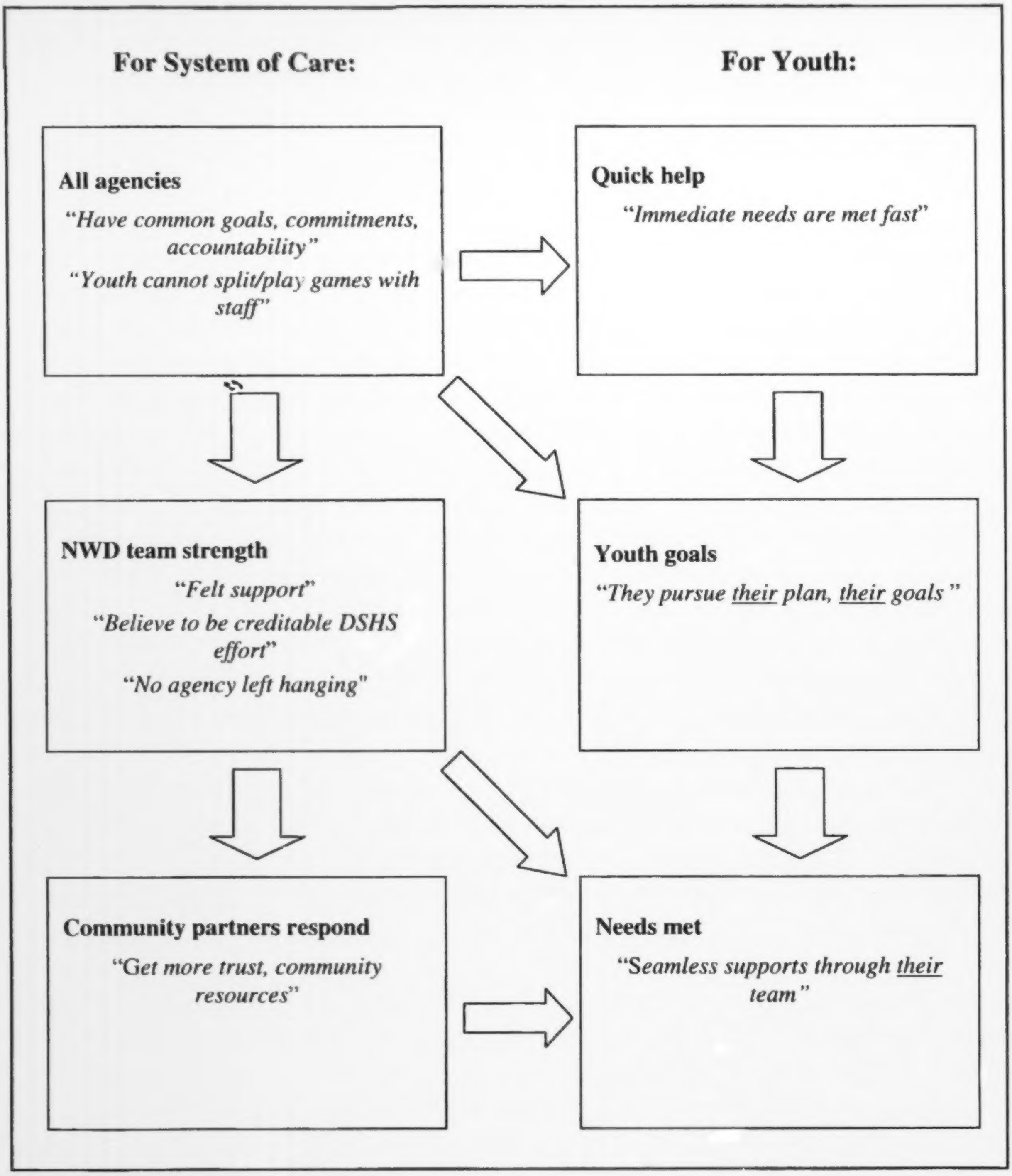
For System of Care:
For Youth:
All agencies
"Have common goals, commitments, accountability"
"Youth cannot split/play games with staff"
Quick help
"Immediate needs are met fast"
NWD team strength
"Felt support"
"Believe to be creditable DSHS effort"
"No agency left hanging"
Youth goals
"They pursue their plan, their goals"
Community partners respond
"Get more trust, community resources"
Needs met
"Seamless supports through their team"

Figure 4.2
Challenges of NWD Youth Yakima Startup

For System of Care:

Lead team member

"Need continuity, time, training"

Solve problem of incentives

"Need to reward efforts with re-allocation of resources saved (cost savings)"

Solve problem of scale

"Need to serve more youth in order to make any impact"

For Youth:

Youth resistance

"Need earlier screening"
"Earlier plan before release"

Lack of help

"Shrinking sources of help and quality services in the community"

Seattle Startup - This startup dealt with the same types of youth as Yakima. However, its objective in system change was very different. It concentrated almost exclusively on cross training child welfare workers in the local offices of the Children's Administration and the community counselors in the local JRA Office of Community Supervision.

A one-day training, attended by most social workers and community counselors, was held in early 2002. Work practices of each administration were explained. Personal contacts were made. The results of this cross training included:

- Arrangements for a better distribution of paper documents about the youth from the institutions to the JRA Community Supervision office, and to the CA offices.
- Coordination of activities around the timing of the release of youth was improved. The major concern was with advance notice of the timing of release of youth from institutions, so that community supervision plans could be made by community counselors, and more importantly, so that placements could be found for the youth by child welfare workers.

The NWD lead in JRA identified youth eligible for NWD 'better coordinated services.' This NWD lead also arranged for an initial coordination meeting for each youth. About eighteen meetings – one for each of eighteen youth - had been arranged in the first twelve-month period of the startup: January through December 2002. These meetings were held once the notice of release was made, typically a few days, or at most a week or two, before the release of the youth from the institution.

Better coordination for each youth was to be achieved through an initial pre-release meeting of at least three people: the youth's CA child welfare worker, a JRA institutional staff, and a JRA community counselor. The purpose of the meeting was to exchange information about the youth and to discuss preliminary post-release plans.

Youth were not normally asked to participate at these meetings. Neither the community counselor nor the social worker took the lead; the two worked cooperatively to coordinate their activities. Personal contacts were made, but this meeting was not expected to produce a firm post-release plan. No future meetings were scheduled at this time.

When asked

- *About strength based, client/family centered approaches or youth specific support teams*, JRA Community Supervision staff said that they were going to be trained in such approaches in the future. Children's Administration staff said that they were sometimes implementing 'wraparound' services for particular youth in need.
- *About the possibility or advantages of some efforts at co-locating staff*, the response was generally favorable. This, however, had not been considered.
- *About the participation of community partners in this NWD effort*, other than JRA and CA staff, NWD staff said that this had not been considered. Both JRA and CA staff had their own network of contacts and contracted providers to deal with mental health and substance abuse issues. Temporary schooling was offered at

the JRA Community Services office when youth had trouble getting access to particular schools.

- *About what better youth outcomes were expected* from the level of coordination achieved, staff said that perhaps youth would complain less about delays in placements, schooling arrangements, and duplication or lack of access to services. Staff was skeptical that any long-term outcomes had been improved – in terms of community reintegration, school achievement, and reduced recidivism.
- *About what further steps in coordination were planned*, staff responded that no plans had been made. But they agreed that only the first steps in coordination had been achieved, and that more training and further coordination are needed.

The above responses were obtained from separate focus groups with Community Supervision staff at the JRA office, and a group of child welfare workers in the CA regional office. No discussion of these issues had occurred across the two administrations.

No common steering committee for this NWD startup has been set up. No regular meetings of Administrations (JRA and CA) had been arranged. It is unclear how further steps will be planned. All local staff said that it had been a good beginning, and that the groundwork had been laid for the implementation of further steps towards service integration.

Plans for the Future: The Families and Communities Together Initiative

The two startups described above are aimed at a relatively small group of DSHS shared 'troubled' clients who are a high-risk and probably a high-cost group of youth. The estimate of the number of such youth, statewide, released yearly from JRA institutions, is about 100-200 youth.

If one considers all troubled youth leaving JRA institutions, rather than only those who are dependents of the state, the estimated number increases to about 600-700 per year. This category includes youth who have received services for mental health, substance abuse, or other disabilities while in JRA institutions. These youth constitute about two thirds of all youth in JRA institutions.

But there is a much larger group of DSHS shared clients that includes 'troubled children and their families.' These are families served by the Children's Administration, who are also receiving services for mental health, substance abuse, or other some disability. In Fiscal Year 1999, there were about 25,000 such families statewide, composed of about 93,000 people. About half of these families also receive economic assistance and may be in WorkFirst.[6]

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[6] **No Wrong Door Report** August 2001, pages 35 and 37.

DSHS managers are trying to develop better ways to integrate services for these families, and to prevent their numbers from increasing. This is a challenging task since current budget constraints preclude allocating extra funding for this purpose.

Successful models of service integration from other states have been studied. Communities whose service integration efforts have been examined include North Carolina; Maricopa County, Arizona; El Paso County, Colorado; Milwaukee, Wisconsin; Louisville, Kentucky; and San Mateo County, California. Some of these communities have achieved better coordination and service integration among state agency programs, some have innovative ways of encouraging participation of various community partners, and some involve new ways of mobilizing communities.

This initiative has identified potential design elements and some key requirements.

Potential Points Of Integration

"Policy Integration	*currently through DSHS Cabinet process*
Physical Integration	*co-location of services*
Case Plan Integration	*currently e on case- by-case basis through staffings or "no wrong door" initiatives*
Intake Integration	*common intake process which may include comprehensive screening and assessment tool*
Service Integration	*unified organizational/governance structure at:* • *RA level and/or* • *AA level and/or* • *line supervisor level*
Information System Integration	*full information access through* • *-protocols* • *-common case management data base*
Program Integration	*change of program rules, policies to harmonize programs*
3rd Party Services Integration	*non-governmental service providers included in the integration model"*

Project Parameters

"Clientele

Families with children needing more than one administration's services

Services

Programs to be integrated include ESA, CA, JRA, DDD, Alcohol and Substance Abuse, and Mental Health.

Families partner in choosing services they will need and use.

There will be a Family Needs Assessment and unified case plan.

There will be a continuum of care from prevention to intervention to post-intervention services.

As many points of integration as possible will be considered, and at a minimum:

physical integration
case plan integration
some level of intake integration
some level of services integration
some level of information system integration"[7]

Two communities in Washington,, Bellingham and Spokane, have volunteered to design community specific models of service integration for these families. They are planning to start implementation in January of 2004. See Appendix 4 for the full text of the proposed Families And Communities Together Initiative.

Summary: Design Elements Implemented and Proposed

Figure 4.3 presents a picture of the design elements implemented by the two NWD Troubled Youth startups.

- The Yakima Startup implemented the required elements and almost all the NWD long term design elements. The exception is flexible use of funding. It is piloting a new communication tool, E-Room, in order to better communicate with team members and store information on the youth, the plan, and the services provided.
- The Seattle Startup implemented elements similar to those required. It developed the first step in implementing the required elements of the NWD startups.

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[7] Source: Families And Communities Together Initiative, April 2003.

Figure 4.3 also indicates the NWD elements in the new initiative.

- The new Families And Communities Together Initiative includes explicitly almost all the NWD long term design elements.

The two pilot communities will design and implement specific integration models from these elements. Which elements will be implemented depends on community decisions.

Figure 4.3
Comparison Between NWD Initial Plans, Achievements and New Initiative Goals for Troubled Youth, Family and Children Services

NWD Initial Plans		Achievements		Goals
NWD Better Practice Elements in Long-Term Design May 2001	*Startup Require-ments* Sept 2001	Troubled Youth Startup 2002		Families and Communities Together
		Yakima	Seattle	
Shared Client Definition / Consent				
Receiving multiple services	Y	Y	Y	Y
Common consent form				
Having multiple needs	N		N	
Client Engagement (Needs and Strengths)				
Client / family / advocate participation and voice	Y	Y	S	Y
Screening tools for multiple needs	N		N	
Planning based on client strengths and problems				?
Meetings at time and location convenient to client				
Appropriate Timing (Early / Late Identification & Services)				
When multiple services occur	Y	Y	N	Y
When multiple needs first arise	N	S		
Appropriate Teams (DSHS, Community, Natural Supports)				
Multi-Disciplinary Teams (MDT)				
Includes different DSHS program areas	Y	Y	N	Y
Develops an integrated service plan			Y	
Composed of direct client support persons				
Includes community partners	N		N	
Includes natural supports for family/customer				?
Provides continuum of coordinated services				Y
Supports appropriate, common client outcomes				
Service Broker / Coordinator (Lead Case Manager)				
To coordinate joint planning	Y	Y	Y	Y
To obtain knowledge of needs			N	
To coordinate delivery of services	N			
To assure needs are met (continuum of care)				
Cross Training (Understanding)				
Each others services (DSHS programs)	Y	Y	Y	Y
Each other processes (culture, language)	N		N	?
Understanding Client-Centered, Strength Based Approach				
Flexible Use of Funding		N		
Co-Location		Y		Y
Continuum of Care (Feedback Loop)				
Technology Application				
Communication about client	S*	S*	N	?
Communication with each other				
Team Monitoring				
Of common service plan	Y	Y	Y	Y
Of services provided	N		N	
Of changes of needs and new plans				
Evaluation				
Of startup implementation (process evaluation)	Y	Y	Y	Y
Of program effects (client outcomes)				

Legend

Y	Yes
N	No
S	Sometime
?	Unclear

* One Troubled Youth Startup, Yakima, is piloting a new communication tool: e-Room.

CHAPTER 5: NWD DISABILITY CRISES STARTUPS

In the Fall of 2001, DSHS leadership decided to implement a NWD approach to resolve crises involving people with multiple disabilities, including those whose behaviors make them challenging to serve. NWD startups in Vancouver and Wenatchee began work in January of 2002. The 'A-Team' model , started in Everett two years before, was adopted for both startups. At least one A-Team was to be formed in each of the six DSHS regions.

People to be served by these startups included those who received or needed two or more of the following services: long term care, developmental disability services, mental health services and substance abuse treatment. Such shared clients were frequently older and single. They often had behavioral issues that made them difficult to serve, and which put their own and others' health and safety at risk.

Crises in the lives of these clients affected not only different program areas within DSHS, but also local hospitals, clinics, police, jails, and Department of Corrections staff. Better coordination among all those who came in contact with these clients was needed to increase effectiveness of services, to decrease duplication, and to find better ways to use scarce resources.

The personnel involved in the startups included supervisors, community organization managers, chiefs and some community wide planners. So, for example, not only mental health clinical directors would be involved, but also local mental health managers of Regional Support Networks who had wider resource planning responsibilities.

The A-Team Model

The A-Team model was one of the innovative ways to better coordinate efforts across agencies presented at the No Wrong Door conference in the spring of 2001. It had been used successfully in Everett for two years. It began as an initiative of local agency supervisors and managers. It had been recognized by the Governor as an innovative initiative that promised to improve government services and may result in overall cost-savings.[8]

DSHS leadership recognized the A-Team model as a useful, replicable service integration initiative. The Aging and Disability Services Administration (ADSA) took the lead in implementing it statewide. The local proponents of the Everett 'A-Team' presented and discussed the main features of their work with their counterparts in other DSHS regions.

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[8] DSHS & Community Partner to Reach Hard to Serve Clients, October 2000, Governing for Results #12, page 65.

Region 6, (Vancouver) and Region 1, (Wenatchee) followed Everett's lead and implemented A-Teams in their communities.

The main features of the A-Team model are:

- A multidisciplinary team composed of

  Local supervisors from the Aging and Disability Services Administration (ADSA) who deal with home and community services (including AAA contracted representatives) and developmental disability services;

  Local contracted providers of mental health services and Regional Support;

  Local contracted providers of substance abuse treatment and county Social and Health Service managers;

  Local hospital or health services representatives;

  Local police, jail representatives and/or Department of Corrections supervisors.
- At least one meeting per month to review 'crisis or challenging' cases, presented by any one of the A-Team members. Typically three to five cases could be discussed in a two hour meeting, resulting in at least thirty six cases reviewed per year.
- Better understanding of the cases presented, and perhaps the underlying pattern of causes, with input of information and perspectives of the different agencies and program areas.
- Problem solving possible resolutions of the cases and situations presented in the most effective, coordinated way.
- Using whatever flexibility exists in regulations and allocation of resources to find a coordinated solution for the particular case presented and, if a pattern exists, for preventing such cases in the future.
- Following up whatever course of action has been chosen to monitor the implementation of the tasks agreed upon, and the overall success of the effort.

To evaluate the performance of the A-Team projects, visits were made to each of the startups and also to the original Everett A-Team. Observations of A-Team meetings were followed by structured focus group discussions, and individual interviews with key A-Team members and regional staff. A few differences were found in the ways that the two new startups operated, compared to Everett. The two new ones are referred to as the Wenatchee startup and Vancouver startup.

Wenatchee and Vancouver Startups - While the original Everett startup used a rotating representative who led the meetings, both the newer startups were led by an Aging and Disability Services (ADSA) representative: an ADSA supervisor in one, and an ADSA assistant regional manager in the other.

Good, steady leadership at the beginning was considered important to quickly obtain the participation of all the various parties to the new A-Team startups. A-team participants in both the new startups indicated that continued respected leadership was important for the continued success of the A-Teams. Staff said: "*We could never have managed to start this fast without the trust people here have for … She puts the interests of the whole client and the whole community first. She gently but forcefully challenges each of us to face up to our collective responsibility.*" Whether rotation of leadership will be possible or advisable in the future had not yet been discussed.

While Everett was a 'bottom-up' effort by local partners who considered themselves equally involved, the more 'top-down' genesis of the Vancouver and Wenatchee projects produced:

- More work for the ADSA leader as the agency designated to call and coordinate meetings, and report all case review results to the DSHS central office in Olympia (in Everett only ADSA cases were reported);
- More work to encourage A-Team members to volunteer in presenting cases to review (since the initiative came from DSHS/ADSA);
- Some confusion on issues of accountability between DSHS and the Department of Corrections (particularly regarding issues of evaluation of the performance of the A-Teams, currently led by DSHS alone);
- Some uncertainty about the authority and flexibility the local A-Teams had to innovate and solve problems without undue scrutiny 'from Olympia.' A-Team participants considered this flexibility crucial for creative adaptation of practices to local conditions.

No substantive differences were found between the ways the two initial startups operated. They conformed to the original A-Team model. They both expected to meet monthly and discuss three to five cases each month. They also conformed with the NWD startup requirements that were appropriate to them. Figure 5.1 shows how what was implemented corresponded to NWD startup required elements.

Figure 5.1
Comparison Between NWD Initial Plans and Achievements for Disability Crises* Services

NWD Initial Plans *NWD Better Practice Elements in Long-Term Design* *May 2001*	NWD Initial Plans *Startup Requirements* *Sept 2001*	Achievements A-Team Startup 2002
Shared Client Definition / Consent		
Receiving multiple services	Y	Y
Common consent form		?
Having multiple needs	N	N
Client engagements (Needs and strengths)		
Client / family / advocate participation and voice	N	N
Screening tools for multiple needs		
Planning based on client strengths and problems		
Meetings at time and location convenient to client		
Appropriate Timing (Early / Late Identification & Services)		
When multiple services occur	Y	Y
When multiple needs first arise	N	N
Appropriate Teams (DSHS, Community, Natural Supports)		
Multi-Disciplinary Teams		
Includes different DSHS program areas	Y	Y
Develops an integrated service plan		
Composed of direct client support persons	N	N
Includes community partners		S
Includes natural supports for family/customer		N
Provides continuum of coordinated services		S
Supports appropriate, common client outcomes		
Service Broker / Coordinator (Lead Case Manager)		
To coordinate joint planning	N/A	N/A
To obtain knowledge of needs		
To coordinate delivery of services		
To assure needs are met (continuum of care)		
Cross Training (Understanding)		
Each others' services (DSHS programs)	Y	Y
Each others' processes (culture, language)	N	
Understanding Client-Centered, Strength Based Approach		?
Flexible Use of Funding		S
Co-Location		N
Continuum of Care (Feedback Loop)		
Technology Application		
Communication about client	N	N
Communication with each other		
Team Monitoring		
Of common service plan	Y	Y
Of services provided	N	S
Of changes of needs and new plans		
Evaluation		
Of startup implementation (process evaluation)	Y	Y
Of program effects (client outcomes)		

Legend

Y	Yes
N	No
N/A	Not Applicable
S	Sometime
?	Unclear

* Disability Crises teams have been called A-Teams.

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Some of the challenges experienced by the two startups were somewhat different, but first it is useful to focus on what they both achieved in the first nine months of operation.

Achievements

A-Team members in both startups identified similar achievements (see Figure 5.2). The list of achievements was obtained by conducting structured focus groups. All A-Team members independently wrote down perceived accomplishments. This was followed by a discussion on how the accomplishments were related to each other.

For System of Care

- More knowledge of other agencies' programs and practices led to a vision of how the parts of the system could work better together: *"Knowing more about other programs, we learned how to support the system as a whole."*
- More linkages and contacts were made so that a network was formed or improved across the various agencies and programs: *"We now support each other as a network."*
- More sharing of ideas and resources was achieved through creative problem solving: *"We brainstormed – We became more open with ways to respond."*
- More efficiency was achieved by relying more on collaborative planning: *"Gaps are filled by others – We save staff time."*
- The community was made a little safer because urgent needs were addressed. *"We do proactive planning, prevention."*

Perhaps most important, members of the A-Team came to really know and trust each other. They recognized that they were part of a multi-faceted system that they had the power to improve.

For People with Multiple Disabilities in Crisis

- People now have options and strategies to cope with the crises: *"Clients get help/services they would not have gotten otherwise."*
- Because of the development of a higher level of service integration, immediate referral is now often possible when other clients are in similar emergency situations: *"Clients get immediate help."*
- Access is now possible to coordinated help that fits the urgent needs: *"Clients have smoother transition through systems."*
- Fewer emergencies and crises may arise due to better monitoring of client progress through the combined efforts: *"Better feedback prevents further safety crises."*

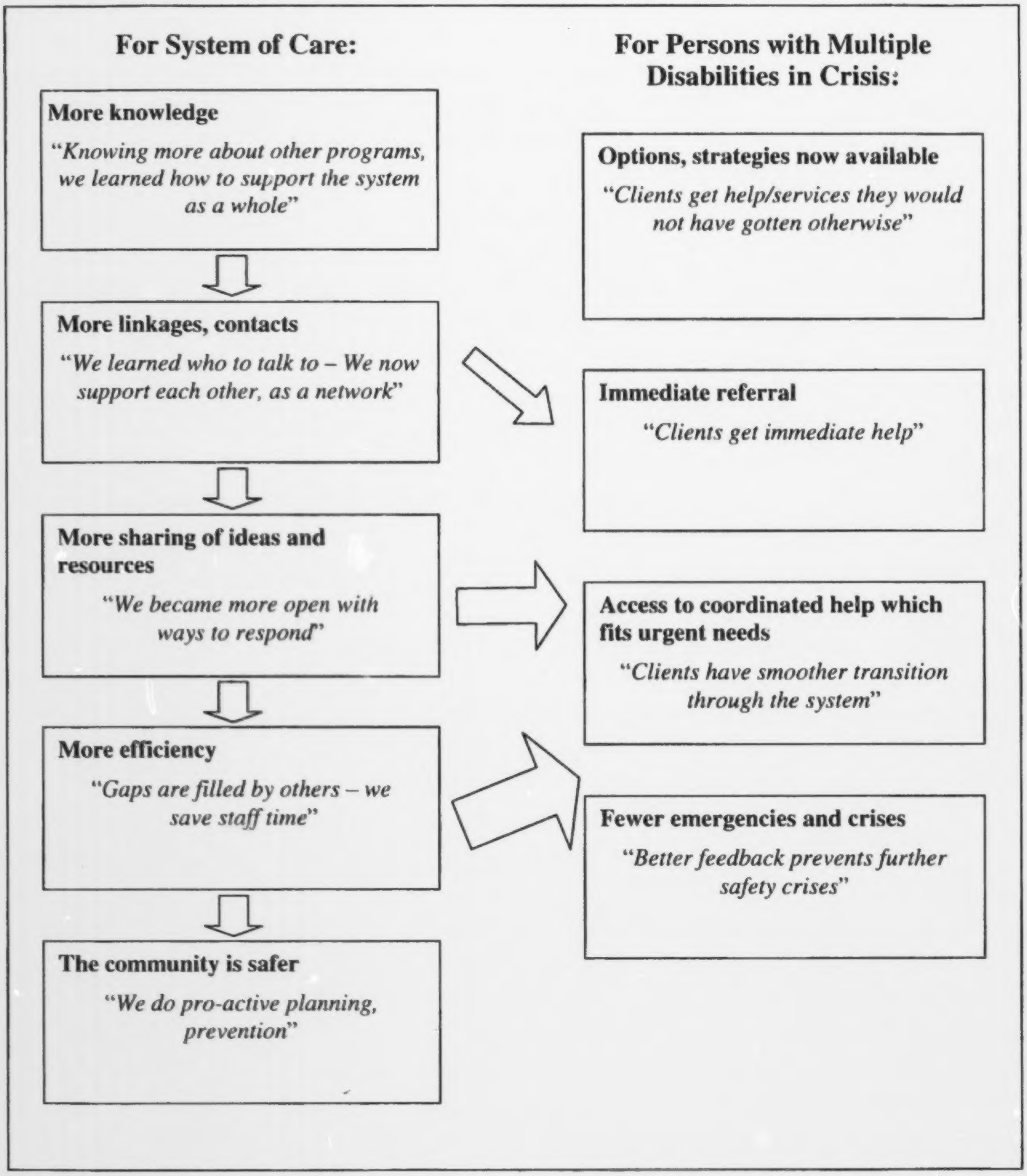
The review of a challenging case at the A-Team meeting helped to better serve the particular person involved, but it also had a "diffusion" effect.

- Supervisors were able to share what they learn at A-Team meetings with staff in their own organizations. They were thus able to disseminate better ways of handling crises. This would lead to faster, more effective responses to other clients. This potentially made the local system of care in that particular community more efficient and cost effective.
- Furthermore, proactive planning when the A-Team confronted similar challenging cases sometimes led to the development of new services or new arrangements. These would hopefully prevent similar emergency situations from getting out of control in the future. It could affect a larger number of clients in similar situations.

It is a bit early for these system-wide improvements to develop in Vancouver and Wenatchee, but there is an emerging discussion of this possibility. Not enough time may have elapsed for similar cases to emerge and patterns to be seen. However, system-wide improvement had been achieved by the Everett A-Team, which is now in its fourth year. The Everett A-Team had been successful in developing new types of placement facilities, and in obtaining funding for other needed services.

Figure 5.2

Achievements of NWD Disability Crises Startups



For System of Care:

More knowledge

"Knowing more about other programs, we learned how to support the system as a whole"

More linkages, contacts

"We learned who to talk to – We now support each other, as a network"

More sharing of ideas and resources

"We became more open with ways to respond"

More efficiency

"Gaps are filled by others – we save staff time"

The community is safer

"We do pro-active planning, prevention"

For Persons with Multiple Disabilities in Crisis:

Options, strategies now available

"Clients get help/services they would not have gotten otherwise"

Immediate referral

"Clients get immediate help"

Access to coordinated help which fits urgent needs

"Clients have smoother transition through the system"

Fewer emergencies and crises

"Better feedback prevents further safety crises"

Challenges

The list of challenges identified by the Wenatchee and Vancouver startups were about 75% similar (see the combined list in Figure 5.3).

For System of Care

The following challenges were identified:

- Lack of resources, particularly health care: *"We don't have Universal Health Care – Resources are limited and shrinking."*
- Rules of the system -Washington Administrative Codes (WACs), eligibility requirements, legal restrictions, accountability practices that do not allow more flexibility: *"Restrictions in use of funding – eligibility rules... legal hoops to jump through for blending $."*
- Lack of continuity of staff: people attending A-Team meetings and general staff turn-over: *"Change in attendees disrupts group process and trust.* "
- Lack of certain family support services and residential alternatives: *"Special support services to behaviorally challenging clients... secure housing...."*
- Lack of better-trained providers and an informed public: *"Providers don't get educated on how to deal with our clients... public is not well informed about mental health behaviors, disability related crises, sexual offenders...."*
- Differences in local interpretations of confidentiality requirements: *"Some say they won't, can't share information... work with us.* "

Many of these barriers are difficult to overcome--particularly funding, legal restrictions, and staff turnover. But when A-Team participants were asked whether they wanted to continue to meet after July 2003, with the certainty of further budget cuts in the future, the response was unanimous: *"Yes, it will be even more important for us to meet... to figure out how to best make do in our community."*

Furthermore, participants recognized that the barriers they faced were barriers for the system of care as a whole. No one part of the system -- no single agency or program -- was identified as problematic.

This holistic view of system barriers was itself an achievement. Realizing that many barriers are shared is often the first step to collectively working to mitigate them.

Various problem-solving activities on individual cases, by different startups, suggests that A-Teams are currently making the most of the flexibility that does exist in rules and funding. They have gained each others' trust and have been working in the "gray areas," helping each other "push the envelope" to find solutions for better supporting shared clients with multiple disabilities, while exercising care not to exceed legal limits.

The Everett A-Team has also started to find ways to get more funding and/or providers to "fill the gaps." None have yet engaged in trying to initiate changes that involve going through "the legal hoops" (trying to change DSHS budget or administrative practices, state legislation, or obtaining federal waivers)

For People with Multiple Disabilities in Crisis

There was consensus on the barriers experienced in trying to better serve people with multiple disabilities with challenging behaviors:

- Clients often were very difficult to engage and did not comply with planned supports and services: *"do not want help – drop-out – do not comply with medications - (ironically) need to create a crisis so we can help, and persons will accept help."*
- Clients often had severe conditions, either very challenging behaviors or conditions which were not likely to improve. So reducing or preventing further harm, and increasing health and safety became the priorities. In the words of some A-Team members, they are *"complicated clients with many needs - can't solve them all – very high-risk – many will not get better."*
- Lack of informal supports (relatives, friends, neighbors, community groups) while their need was crucial: *"Many have no supports,"* and often *"follow-up agency supports are not available after the crisis."*
- Response time to crises was too long, while client need for help was urgent: *"It takes too long, sometimes, to find the right way to help."*

A-Team members often accepted the limits to what they can do, but nonetheless they explored all avenues and angles. They often sought less expensive ways to reduce possible future harm for the clients and the community. This was not easy, especially since they could not implement solutions against the client's will. Discussion of possible solutions always took account the client's right to self-determination, but was balanced with concerns for the safety of others.

Figure 5.3

Challenges of NWD Disability Crises Startups

For System of Care:

Lack of resources

"We don't have Universal Health Care – Resources are limited and shrinking"

Rules of the system

"Restrictions in use of funding, eligibility – Legal hoops to jump through for blending dollars "

Lack of continuity of staff

"Changes in attendees"

Lack of certain family support services and residential alternatives

Lack of better educated providers and informed public

For Persons with Multiple Disabilities in Crisis:

Client engagement and compliance

"Do not want the help – drop-out – do not comply with medications – need to create a crisis to help"

Client severe conditions

"Complicated clients with many needs – can't solve them all – very high risk – many will not get better"

Lack of informal supports

"Many have no supports – Follow-up agency support after crisis is not available"

Response time to crisis

"It takes too long, sometimes to find the right way to help"

Future Directions

Statewide Implementation

The plan was to start at least six A-Teams, one in each of the six DSHS regions. There are now nine, six more than the original one in Everett and the two startups analyzed in this report: Vancouver and Wenatchee. The new A-Teams were mainly formed in the first six months of 2003.

They are located in Spokane, Pasco/Tri-Cities, Bellingham, Mt. Vernon, Seattle and Tacoma. All the DSHS regions are covered, as are most of the larger urban centers.

The Medicaid Integration Project

A-Teams deal with crises that persons with multiple disabilities may encounter while served by different DSHS programs. Other persons with multiple needs are not in crisis, but may use different services intensively. This project aims at better coordinating services for clients who are most medically needy and also have long-term care, mental health and chemical dependency needs. The objectives of this project, as stated in the request for proposal (RFP) drafted by the Medical Administration, are:

- *"To integrate primary, acute, and long term care services into one consumer driven managed care system;*
- *To ensure that clients receive the appropriate level of care in the least restrictive setting consistent with their personal health and safety;*
- *To improve access to health care and improve the quality of that care; and*
- *To create accountability and controls on costs and outcomes of care".*

The managed care plan will be expected to better assess client needs and better coordinate client care across various DSHS program areas. The specific ways this will be accomplished depends on the responses to the RFP by the three medical service plans that have expressed interest.

The expectation is that the contracted plan will provide care through a network of long term care, mental health, and chemical dependency providers. The plan is likely to contract with currently licensed providers. Up to six thousand clients will be enrolled in the next two year, as a pilot project, mainly in the urban areas of the state.

General Concerns and Specific Recommendations

Concerns

The following major concerns emerged during interviews with the lead organizers of the two start-ups, key members of the two startups, the Everett A-Team, and two regional ADSA administrators:

- ***"How flexible could the A-Team model be?"*** Many crisis resolutions occurred informally, without an A-Team intervention, particularly in smaller communities, where networks of providers and agency staff already existed. Could the A-Team review more intractable cases as examples and problem solve more systemic policy issues? This would leave regular crisis resolution to proceed informally, through the network of contacts across agencies and providers.

  If more informal problem solving was recommended at the level of front line staff, then more client-centered planning could occur. Clients, relatives, advocates or other natural supports could participate, if possible, in the planning. Front line staff that knew the clients could more easily find informal supports, if they existed. Outcomes might be easier to track since front line staff would write follow-up case notes as part of their regular work.

- ***"How accountable do the A-Teams have to be, and to whom? What performance measures are appropriate?"*** The first concern is over the degree of oversight from Olympia. Since A-Teams seek community-specific ways to improve service delivery, centralized control is seen as an obstacle to flexibility in doing this.

  The related issue regarding performance measures is more complex: if a single statewide measure is to be used, like the number of cases reviewed, all A-Teams would have incentives to review many cases, instead of resolving them informally, or spending time on policy issues.

  Lastly there is the issue of who to report to: DSHS, DOC or both? Since county and regional entities are also involved, should they report to them as well?

- ***"What about small communities in the various regions? How about relations with tribes?"*** The territories covered by existing A-Teams are now larger urban areas. Efforts at more regional teams reviewing problematic cases had not worked in the past, since members needed local expertise with community specific social/health systems and local providers. Regional representatives did not have this expertise across numerous small communities. The current statewide implementation plan did not address crisis resolution strategies for smaller communities in each region.

  A related issue was the relation of the A-Team to the tribes. Would the autonomy of tribes be violated if they participated? And who would participate from the tribes? Consistency in participation is considered essential, but some tribal representatives change often.

Recommendations

Some specific recommendations were offered:

- Administrative costs for organizational and reporting requirements, now borne by ADSA alone, may need to be compensated. An estimated one half-time person per region is needed.
- Information required on reporting forms for case reviews could be shortened and simplified.
- Some issues of client access to services are not resolvable by increased communication. Procedures for exception to policy or rules or legal authority for more flexibility may be needed, and may be best achieved centrally.

CHAPTER 6: CONCLUSIONS AND ISSUES FOR FURTHER STEPS IN SERVICE INTEGRATION

Conclusions

- Staff say that shared clients are significantly better off due to the NWD startups.
- DSHS staff, other agency partners, and in some cases community partners, have been able to work together successfully in new, more client-centered, collaborative ways. All participants are generally in support of such changes.
- New ways to improve and support these initiatives and to overcome barriers and challenges have been identified, and many are being developed locally and by DSHS administrations.

Some challenges require resolution from central NWD coordinators and DSHS managers. The ones discussed here are those suggested by DSHS staff and service providers involved in NWD startups. They are challenges for existing startups, and for the implementation of the new service integration initiatives. Local NWD startup staff consider their resolution essential to taking further steps in service integration.

Next Steps in Service Integration: Suggestions From The Field For Central NWD Coordinators

Interviews with some of the startup staff identified emerging issues that are not easily handled locally or by a particular lead agency. These issues may require development of solutions by DSHS leadership and No Wrong Door central coordinators. They represent issues across different types of multiple-needs clients, different DSHS program areas, different state agencies and different communities. Therefore, NWD staff argue that they are best resolved centrally. They involve both policy issues – what general strategies should be pursued, and also implementation issues – what new tools or rules should be developed.

Key Policy Issues: General Strategies to be Pursued

Need for service integration at the 'Front-end' vs. maintaining the focus at the 'Back-end' of the system of care – The issue is whether NWD startups should continue to focus on the identification of multiply-served, complex, high-risk, high-cost clients at the 'back-end' of the system or move to an earlier identification of multiple-needs clients and coordination of more preventive services at the 'front end.' Starting earlier would require more partnerships with community organizations, in addition to coordination among state agency programs. This may result in even better client outcomes and perhaps more cost savings due to the prevention of predictable, subsequent costs.

The emphasis of the NWD startups has been on coordination among state agencies and DSHS programs. All the front-line staff interviewed saw this as a necessary first step. They acknowledged that this focus on state agencies was a product of the short time available to implement the NWD startups. It takes much more time to set up community partnerships and to mobilize large numbers of staff to change the 'front-ends' of systems of care.

However, many believe that successive steps should be taken to move towards more service integration at the 'front-end.'

- NWD WorkFirst startup staff suggested moving to an earlier identification of clients with multiple needs in order to increase the probability of engaging clients, getting clients employed, and decreasing the amount of time clients receive economic assistance. This is what the Economic Services Administration is proposing for statewide implementation.
- NWD troubled youth startup staff and steering committee members recommended moving their wraparound team approach to a larger proportion of troubled youth, earlier in their lives. They saw this as a necessary next step to gain more interest and funding from potential community partners.
- Some NWD disability crisis startups and some A-Teams have started going beyond reviewing difficult cases to deal with policy issues. They would like to be able to develop new types of services and staff arrangements. These are aimed at trying to decrease the number or intensity of crises for people with multiple disabilities, in order to increase client and community safety and reduce costs.

Decentralized (community-based), centralized (agency-based), or combined accountability – The question raised by at least two startups concerns the degree of flexibility communities should have in implementing service integration. Some participants fear that more centralized accountability, depending on what reporting was required, could have counter-productive consequences: more centralized accountability could lead to worse, not better outcomes.

If performance standards include process measures, they implicitly specify particular ways of achieving ultimate goals. This would discourage creativity in exploring different processes and in adapting processes to different local situations. If intermediate goals are specified, rather than ultimate goals, alternate ways of achieving ultimate goals are also discouraged.

Suggestions were made to have

- Flexibility in how goals are achieved, within some overall vision or a basic set of principles, and
- Fixed monitoring and accountability on performance measures of agreed-upon ultimate goals, to be distributed locally to community partners, steering committees and to various participating state agencies. Some general goals may be set statewide, but specific goals would be decided locally.

Competition of many local 'steering committees' for service integration – Already in some communities, startups have encountered the question of whether to set up different coordinating committees for each of the NWD initiatives.

One CSO administrator, already participating in a successful and ongoing NWD Troubled Youth steering committee, wondered whether to start another one for the NWD WorkFirst startup. He was hesitating because he realized lots of overlap existed among participating agencies and staff. He also wondered whether there would be membership overlap between these two steering committees and the A-Team. He noted that some of the issues discussed by these different committees would be different, but some would be quite similar.

A manager for a contracted substance abuse treatment provider wondered whether she would be involved in three new NWD coordination committees. It is common for providers to participate in multiple community networking groups, but her time was limited. She wondered about efficiencies; about whether she would have to choose whether to participate in some efforts, and not in others, based on her own priorities.

This is not a simple issue. The overlap of coordination issues and membership argues for a common steering committee. The advantages of focusing on particular sets of shared clients and on resolving barriers specific to them argue for setting up different steering committees.

Co-location or out-stationing staff – While front line staff pointed out that coordination was facilitated by proximity in physical location, they wondered how the NWD initiatives for WorkFirst and troubled youth would resolve location issues. There was significant overlap in the types of clients and staff involved.

One CSO lead worker asked whether the new building planned for the consolidation of her staff in one large office, instead of multiple smaller ones, took into account planned co-location for other NWD initiatives.

One child welfare worker asked how she could possibly be out-stationed in more than one place.

More that one front line staff asked whether this issue was being discussed by central NWD coordinators.

Implementation Issues: New Tools to Develop

Development of early screening tools for multiple needs – Different program areas employ their own screening procedures and tools for the same need. Some localities are developing custom tools for use by partner agencies. But many believe that a set of universal screening tools would be more useful and efficient. The development and consolidation of existing screening forms into a single, agency-wide instrument with "modules" for each type of need is being addressed as part of the Families and Communities Together.

For example, one chemical dependency counselor said that she had been frustrated with the inadequacy of the few questions currently used by CSO staff for screening substance abuse. She noted that she had to give full assessments to many clients referred to her, and many of the clients were not found to be chemically dependent. She was also troubled with the length of the full chemical dependency assessment, which used up too much of her time. Staff at the local chemical dependency assessment center drafted a possible alternative tool to better screen clients with potential substance addictions.

Some Employment Security Department (ESD) staff who work with WorkFirst clients indicated that they would like to be trained to recognize mental health issues. They said that clients often do not reveal these problems to CSO staff, especially at the beginning. However, after some months, as they get to trust staff more, they start talking about these issues. When this happens, ESD staff want to know when and how to refer these clients for possible help.

Development of tools to better track No Wrong Door clients, their plans and outcomes – Startups have been forced to develop their own ways to track information about the number of people served, who was served, how, and with what outcomes. Some startups are using custom Excel databases. Some have continued gathering paper and pencil documents. Some have adapted existing electronic Management Information Systems to incorporate NWD service plans and follow-up information (such as E-JAS and CAMIS). However, these are only accessible to some state agency staff, not to others, and not to community partners.

Many have asked for guidance on what they should do. One startup suggested specific modifications of paper forms now in use.

The e-Room collaboration software is being pilot tested by two startups. It can improve electronic communication among state agency and community partners on multidisciplinary teams. It can also store information on the clients and their progress. This information can be set up so that it is shared exclusively with multidisciplinary team members from diverse agencies and community partners, with the consent of the client in the signed Release of Information form.

Procedures for overcoming legal/accounting problems in blending funding or re-allocating cost-savings to finance upfront NWD efforts – Two startups suggested that while some flexibility could be attained by local community NWD efforts, this flexibility was ultimately constrained by barriers which could not be overcome locally. Assistance from central authorities was needed in term of "going through the legal hoops." Reallocation of cost-savings may require either changes in central administrative accounting rules and/or obtaining federal waivers. The use of braided funding often means the development of different, more complicated accounting procedures.

Reflections on the Interrelations among the Issues

As mentioned at the end of Chapter One, the strength of service integration is in its fostering personal relationships, exchange of knowledge and mutual support between different front line staff and service providers who might otherwise be isolated and frustrated. Staff say that they are willing to continue doing this work not only because it is better for the clients, but also because it is better for their own morale and working conditions. This may reduce staff turnover, which creates lack of continuity and is one of the perceived obstacles to success.

However, cost savings to the system don't return to the people who make them happen. Startup staff say that while they are willing to continue doing this work, it may not be possible to expand it without financial support.

Furthermore, staff argue for the expansion of NWD integrated services and screening to clients with multiple needs much earlier. This is widely viewed as likely to overcome some of the clients' resistance and distrust. Clients reached early on are much less likely to have accumulated negative experiences with the 'system' or personal failures. They may be offered help at the right time, early on, before defeatist attitudes have set in and the chances of productive engagement may be highest. This would necessitate an expansion of NWD integrated services to more clients, involving more staff time and somewhat higher upfront costs.

NWD Design Elements and Issues to be Resolved

Figure 6.1 presents a representation of the correspondence between NWD long-term design elements that were not initially required for the startups and the issues that still need to be resolved.

The darker shaded boxes depict the NWD long term design elements that were not required for the startups. The shaded boxes in the second column, numbered from one to seven, represent the four policy issues and the three implementations issues still to be resolved.

Figure 6.1
NWD Staff Suggested Issues to be Resolved for Design Elements Not Required Initially for Startups

NWD Initial Plans		Issues
NWD Better Practice Elements in Long-Term Design May 2001	*Startup Requirements* Sept. 2001*	*NWD Staff Suggestions Fall 2002*
Shared Client Definition / Consent		
Receiving multiple services	Y	
Common consent form		
Having multiple needs	N	1
Client Engagement (Needs and Strengths)		
Client / family / advocate participation and voice	S**	
Screening tools for multiple needs	N	5
Planning based on client strengths and problems		
Meetings at time and location convenient to client		
Appropriate Timing (Early / Late Identification & Services)		
When multiple services occur	Y	
When multiple needs first arise	N	1
Appropriate Teams (DSHS, Community, Natural Supports)		
Multi-Disciplinary Teams (MDT)		
Includes different DSHS program areas	Y	
Develops an integrated service plan		
Composed of direct client support persons	S**	
Includes community partners	N	3
Includes natural supports for family/customer		
Provides continuum of coordinated services		
Supports appropriate, common client outcomes		
Service Broker / Coordinator (Lead Case Manager)		
To coordinate joint planning	Y	
To obtain knowledge of needs		
To coordinate delivery of services	N	3
To assure needs are met (continuum of care)		
Cross Training (Understanding)		
Each others services (DSHS programs)	Y	
Each other processes (culture, language)	N	
Understanding Client-Centered, Strength Based Approac		
Flexible Use of Funding		7
Co-Location		4
Continuum of Care (Feedback Loop)		
Technology Application		
Communication about client	S***	6
Communication with each other		
Team Monitoring		
Of common service plan	Y	6
Of services provided	N	
Of changes of needs and new plans		
Evaluation		
Of startup implementation (process evaluation)	Y	2
Of program effects (client outcomes)		

Legend for Startup Requirements

Y	Yes
N	No
s	Sometime

Legend for Policy Issues

1	Front-end or back-end integration?
2	Centralized accountability or flexibility?
3	One community steering committee?
4	Co-locating or out-stationing staff?

Legend for Implementation Issues

5	Development of early screening tools
6	Tracking shared clients plans & outcomes
7	Re-allocating cost-savings & funding flexibility

* Startups were for long-term TANF clients, multiple disabled in crisis and youth leaving JRA institut

** A-Teams have standing teams of line staff supervisors and no direct client partic

*** Two startups are piloting a new communication tool: e-Room

Figure 6.1 highlights issues identified by the NWD startup staff concerning better practice elements that were considered difficult to implement in the short run, and therefore postponed. These elements were not required in NWD startups.

NWD startup staff see the need to resolve these issues which impede achievement of NWD goals. . They are issues that staff recommend should be tackled next by DSHS central authorities. Staff see resolution of these issues as necessary to facilitate further steps in service integration

APPENDIX 1
NWD RECOMMENDATIONS

What Recommendations Were Made to the DSHS Cabinet?

Key Elements for No Wrong Door Startups

Agreement was reached on the essential characteristics that all No Wrong Door models should include in the long run. All but the last two were also recommended for the startups. The key elements of the long-term case coordination model were:

- ***A Multi-Disciplinary Team*** composed of appropriate DSHS program staff members, local community organizations, natural supports to the customer/family, and the client or advocate when possible, to develop an integrated service plan.
- ***A client-centered integrated service plan*** based on the client's strengths, risks, service desires and service needs.
- ***Cross training*** among the multi-disciplinary team to insure a general understanding of each other's services and processes.
- ***A service broker/coordinator*** to coordinate the joint planning and coordinated delivery of services for the customer.
  (Note: a lead case manager may provide this function.)
- ***Information technology applications*** that are secure and easy-to-use, to help the team communicate with each other about each shared client.
- ***Monitoring and evaluation*** of the service plan, services and outcomes to allow the team to make model changes, when appropriate, and to allow RDA to accurately evaluate the impacts of the startups.
- ***Flexible use of funding*** among the multi-disciplinary team to ensure that the client receives services for which he/she is eligible.
- ***Co-location*** of the team to make it easier for the shared client to obtain services and to allow the multi-disciplinary team to learn to work well together. If co-location is not possible, the out-stationing of some service providers and the nearby office location of others could be tried.

The design teams also created a common set of values, a flow chart for coordinated services, and a narrative on ideal models of case coordination.

What Recommendations Were Made About the Long-term Model for Case Coordination?

The three design teams, even though working separately on different types of shared clients, created a common set of values and a common long-term ideal flow chart for case coordination.

The design teams believed that the values and the long-term model should guide the development of short-term startup designs. They thought that by keeping long-term goals in mind it would help build short-term startups, and gradually resolve barriers to case coordination.

The common set of values and the ideal flow chart and narrative for case coordination are presented in the following pages.

No Wrong Door Values

Accountability: We are accountable to many stakeholders by:

1. Providing timely and comprehensive services;
2. Serving customers efficiently;
3. Serving customers effectively and measuring our outcomes;
4. Measuring customer satisfactions; and
5. Using a comprehensive management information system.

Respectful Environment: We provide a welcoming and supportive environment by:

1. Acknowledging and honoring the diversity of our customers and our staff;
2. Responding quickly to customers' inquiries;
3. Recognizing that quality services can be provided in uniquely different settings; and
4. Supporting our staff in their decisions to serve our customers well.

Customer-centered Services: We will provide consumer-driven, flexible services that respond to the unique needs of each individual and family by:

1. Respecting our customer's choices;
2. Providing cultural relevant services; and
3. Emphasizing holistic and strength-based services.

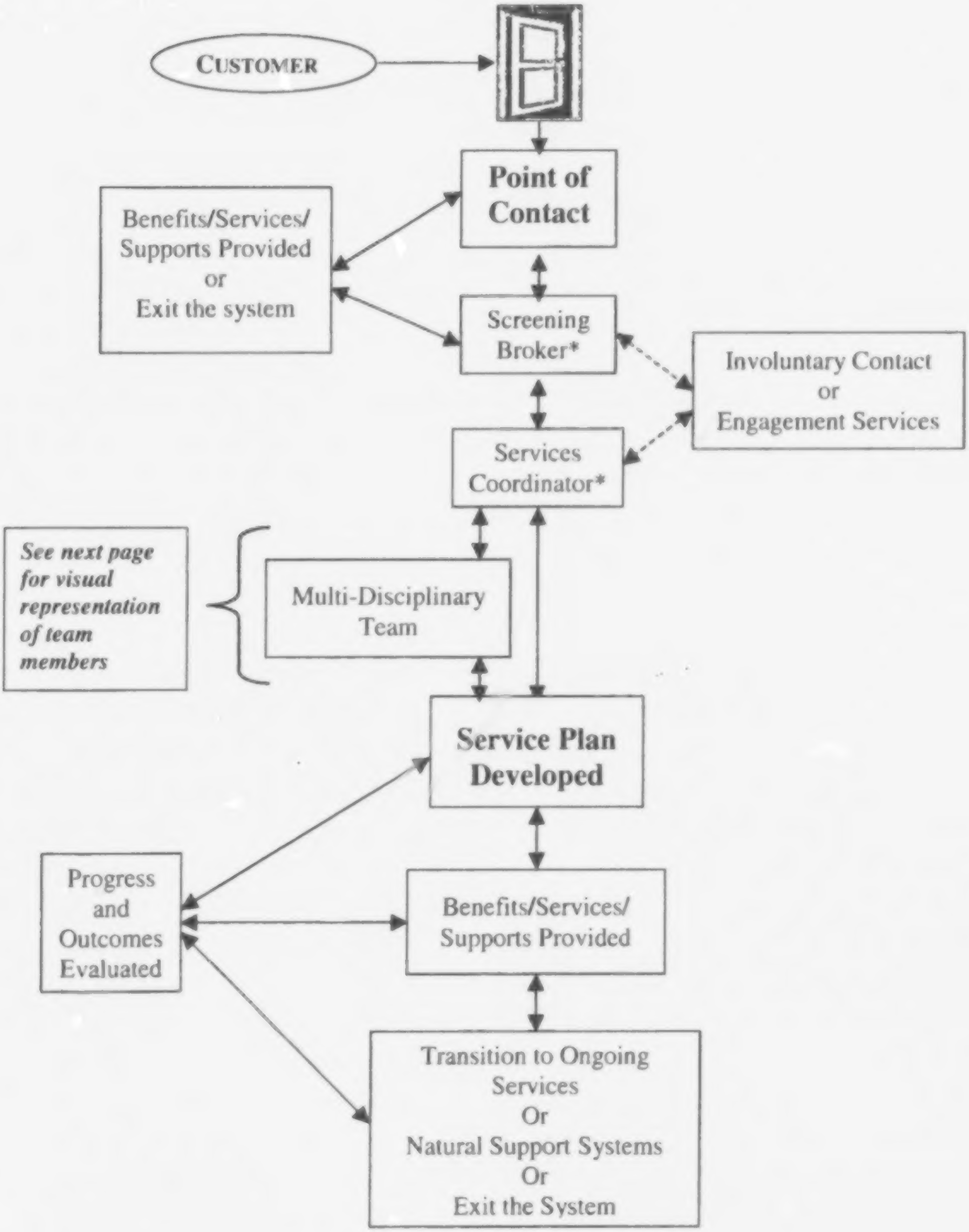
Partnerships: We maximize state and community resources by:

1. Knowing DSHS and community resources available to our customers;
2. Working in multi-system teams;
3. Combining both natural and professional supports;
4. Using the broadest definition of family and community; and
5. Respecting and supporting our partners. (suggested by DSHS Secretary Dennis Braddock)

Quality Workforce: We are the workforce that is:

1. Respectful to customers;
2. Knowledgeable about program services in all divisions;
3. Diverse;
4. Supportive of our colleagues; and
5. Using quality principles to work toward a positive change.

No Wrong Door: Ideal Flow Chart for **Case Coordination**


CUSTOMER
Point of Contact
Benefits/Services/ Supports Provided or Exit the system
Screening Broker*
Involuntary Contact or Engagement Services
Services Coordinator*
See next page for visual representation of team members
Multi-Disciplinary Team
Service Plan Developed
Progress and Outcomes Evaluated
Benefits/Services/ Supports Provided
Transition to Ongoing Services Or Natural Support Systems Or Exit the System

Multi-Disciplinary Team

Community Partners

- Hospitals
- Universities
- Head Start
- Parks & Recs & YMCA
- Parent to Parent Consumer Networks
- Public Health
- Schools
- Business

Natural Supports

- Friends
- Neighbors
- Church

- Extended Family

DSHS Program Areas

- Child Care
- Juvenile Justice
- Child WorkFirst
- Health Care
- Supports for Persons with Developmental Disabilities
- Home & Community Services
- Job Skills Training
- Chemical Dependency Treatment
- Mental Health
- Job Development

Narrative for the Ideal Flow Chart of Case Coordination

Customer

An individual and/or family actively involved in decisions concerning needed services that depend on the timeliness, accuracy, and quality of another's work.

*Point of Contact

Contact may occur on the customer or advocate's initiative, community referrals, or involuntarily (as in cases involving abuse, neglect, or criminal justice system). Initial contact may take place in a variety of ways including: person-to-person, telephone, Internet, or other technological interface.

*Screening Broker

An experienced worker familiar with all DSHS services as well as community resources and partners. The broker is cross-trained to assess the holistic needs and make referrals to the appropriate services or Services Coordinator. The Screening Broker identifies the needed service(s) with the customer. In the case of a single service, the Screening Broker makes the referral and/or provides the service. A referral to a Services Coordinator is made for complex cases. Each agency will have a designated Screening Broker, available during business hours, responsible for making or receiving referrals.

Single Service:

- Make a referral to the designated Screening Broker at the appropriate agency.
- Arrange the service if it is the target agency where the service exists.

Multiple Service:

- Make the referral to the appropriate Services Coordinator as determined by the universal screen that identifies the primary service need via that agency's Screening Broker. (Referrals are made from Screening Broker to Screening Broker.)
- This function must be supported by adequate and accessible data as well as information systems.

Involuntary Contact or Engagement Services

These customers may have multiple or single needs and enter the system differently, often through a crisis or the justice system. They may be in denial, resistant, and/or hostile. These customers will have access to a Services Coordinator and the same services as the voluntary customer. Engagement services may also include outreach activities. (This mode of entry is represented by a dashed line to represent an alternative method of access to services)

*Services Coordinator

A DSHS staff member or contracted service provider who is identified as most appropriate to address the customer's primary need. This person, with expert program knowledge, performs or coordinates such tasks as a comprehensive assessment, eligibility determination if required, and the provision or arranging of services.

If multiple needs are identified, the Services Coordinator is then responsible for ensuring the development of a holistic and integrated service plan. The Services Coordinator is also responsible, in collaboration with the customer and others, for maintaining, evaluating, revising, changing or terminating the plan. When necessary, the Services Coordinator will also be responsible for convening and facilitating a multi-disciplinary team. Whenever possible, the customer will choose the members of the team. The Services Coordinator may change over time, depending on the predominant issue facing the customer or family.

Multi-Disciplinary Team (as needed)

The Multi-Disciplinary Team is a diverse and culturally competent team utilized to develop an integrated service plan and provide services to support desirable outcomes for the customer.

Service Plan Developed

The customer service plan, based on customer strengths, will serve as a guide or contract that leads to the desired outcomes of self-sufficiency, health, and safety for the customer. When possible, the plan should be driven by the customer, advocate, and/or family. The development of the plan should occur in partnership with the relevant service providers, courts, and community supports.

Benefits, Services, and Supports Provided

Benefits, services, and supports include the identified or contracted goods and services originating from the service plan.

Progress and Outcomes Evaluated

Recognizing that service needs of a customer may change, revision of services is an ongoing process through review and evaluation.

Transition to Ongoing Services, a Natural Support System, or Exit the System

A transition could be a change in service and/or coordinator, or the termination of service.

The transition will consist of a plan that will continue the goal of self-sufficiency, health, and safety, and provide assistance in building natural or community supports. The complete customer history and documentation should follow the customer when appropriate.

APPENDIX 2

DENNIS BRADDOCK - SEPTEMBER 21, 2001 NWD GUIDANCE Memo

September 21, 2001

TO: Assistant Secretaries
Division Directors

FROM: Dennis Braddock
Secretary

SUBJECT: No Wrong Door Start-up Guidance.

Thank you all for your efforts in initiating No Wrong Door in the Department. Implementation of these activities will bring us even closer to realizing our potential for providing effective, full-spectrum services to DSHS clients. Starting with the kick-off conference in April, through organizing efforts, staff has devoted a substantial amount of energy and creativity to this goal. Now I am asking that we go the next step to formalize the collaborations that have been undertaken and encourage those administrations that have not yet begun a start-up, to identify areas where we can make a difference. We have developed minimum requirements for the start-ups building on the target groups already established and maximizing use of the tools and skills available in the department now.

As you know, one of the department goals in our Performance Agreement with the Governor is to implement a minimum of 3 No Wrong Door Service integration start-ups by July 2002. I would like us to have collaborations underway in all the Administrations by January 1, 2002. I want you to think in terms of projects that are of immediate benefit to our clients, and will become an integral part of your program. The scope may be limited initially, but will be something you can build on for the future.

Because of the high priority the department is placing on the No Wrong Door process, I have asked Laurie Evans to serve as project coordinator while we are getting the start-ups underway. If you or your staff have questions or need assistance, she may be reached at (360) 902-7505, or by e-mail.

I do not minimize the amount of coordination and work involved in setting up these projects. On the other hand, to fail to provide services in an integrated way wastes money and denies our clients needed services.

Minimum Requirements

The following are the minimum requirements for start-ups. If you have already begun a project, review it against these guidelines and assure that all requirements are being met.

Please submit your projects plans to meet requirements by October 12, 2001 using the attached reporting format (attachment A).

1. **Target Populations** - the start-ups must concentrate services on one of the following three target populations.

- Long-term TANF Families - Families that have been on TANF for 36 continuous months. During the past year, some member of the household received services from AASA, DDD, MHD, DASA, or DVR, or is receiving SSI, GAU, or GAX.
- Troubled Children, Youth, and their Families - Children who have received services from CA or JRA. During the past year, some member of the child's household received services from AASA, CA, JRA, DDD, MHD, DASA, or DVR, or is receiving SSI, GAU, or GAX.
- Clients with Multiple Disabilities - Clients who have used services from at least two of the following programs during the past year: AASA, DDD, MHD, and/or DASA.

2. **Multi-disciplinary Teams (MDT)** – the start-up must involve a Multi Disciplinary Team composed of staff from department divisions who share a mutual client. It may also include case managers from systems outside the department. Be sure to include the tribes as appropriate. The MDT will review the client situation and, in a collaborative way, determine what the best service plan for the client is. These should be ad hoc teams, composed of the client's case managers, not a standing team that reviews many cases. The exception to this requirement will be the AASA A-Team, which is a standing committee.

3. **Client Involvement** – the start-up must involve the client or his representative, where possible, in case direction and decision-making.

4. **Cross Training** – the start-up must identify ways the divisions will ensure that their staff are aware of the programs and services offered by the other involved divisions. ISSD is also working on ways to share program information, but until they are able to develop a way to do that, project plans must include a description of how team members will learn about each other's programs.

As a first step toward developing the ISSD tool, please provide a one or two page program eligibility/qualification sheet for each of your divisions' programs. There is no particular format required at this time. These are also due October 12th.

5. **Release of Information** – a team of staff from all the divisions has developed the " Consent to Exchange Confidential Information for Services Coordination" form, DSHS 14-012. It covers all privacy and security contingences for every program. The start-up must have a completed form for every client in the project.

6. **Client Registry** – the start-up must use the Client Registry as a tool for identifying case coordination entities.

7. Collaboration Software – ISSD is developing the capability for case managers to communicate with each other and store case information in a secure electronic place all involved parties can access. Training will be provided. When it becomes available, start-ups will be required to use it.

8. Client Services - Staff are encouraged to develop creative collaborations between divisions in the delivery of services to mutual clients. Staff sometimes feel hampered by program budget rules from developing the services they believe clients need. They may not be aware that a particular budget guideline can be waived. You should develop a process within your administration for clearing these questions.

Technical Assistance

Client Registry –

All administrations now have staff access to the Client Registry. However, usage of the system is low. This may be a function of staff turnover since training took place in the local offices. We will identify a pool of trainers in your area from which you can draw. If you have staff who need training, trainers are available in your local areas. Dave Sugarman, manager of the Client Registry, will help identify potential trainers. His number is (360) 902–7869.

Team Facilitators –

If your start-up planning would benefit from the assistance of a facilitator, CQI trainers and facilitators are available in your local areas. If you are having trouble finding someone, contact your Administration Quality coordinator.

Project costs –

A limited amount of start-up seed money is available from the Secretary's office for helping build the infrastructure for your projects. However, once underway, start-ups should be self-sustaining without additional funding outside your program budgets.

Project Plans

The start-up project plans are to be submitted using attachment A. Again, they are due to the Secretary's Office by October 12th. Once they are approved, you will be asked to submit a monthly progress report. Attachment B is a sample implementation plan/ progress report. It is done in Word and can be expanded or changed to fit your start-up. If you or your project teams would like these documents in an electronic form, contact Laurie Evans at (360) 902–7505, or by e-mail.

Thank you for all the work you and your staff have already done, and will do. We all share the same mission and the same desire to provide the most complete, quality service we can to our communities. Working together is the best way to assure the fulfillment of that promise.

cc: No Wrong Door Executive Team
No Wrong Door Design Team Members

No Wrong Door Start up Plans

Start-up Name: (A descriptive title)

Start-up Sponsor: (The sponsor will oversee the project and assure timelines and budget expectations are met. There could be multiple sponsors from all affected divisions, but a prime sponsor, who can be contacted and who will be responsible for reporting, must be identified.)

Start-up Lead: (The project lead will monitor day-to-day operation of the start-up. Again, each division can identify a project lead, but there should be a prime lead responsible for coordinating project activities.)

Start Date: (This is the day you expect the first case to be started through your process.)

Divisions involved: (List the divisions involved in the project. Include any outside agencies)

Start-up Description

Charter/Concept – (Describe the goals of the project. Describe how the concept will work. Describe the process. What happens when a client walks through the door and presents him/herself to a case manager?)

Mandatory Elements:

- **Multi-Disciplinary Team** – (How will it form? If there will be a primary case manager, how will he or she be identified? What will the scope of the team decision-making be? How will required services be determined and who will fund them? How will the team communicate with each other? How will outside stakeholders be involved? What will the dispute resolution process be?)
- **Client Involvement** – (How will the client be involved in decision-making regarding services?)
- **Cross Training** - (How will you assure that all case managers are aware of each others' programs and services?)
- **Release of Confidentiality** – (Describe at what point the release will be obtained and hoe it will be used within and without the department.)
- **Client Registry** – (describe when and how the startup will use the Client Registry as a resource for identifying mutual clients and cross-divisional case management.)
- **Waiver Process** – (describe process for MDT's to obtain waiver from budget restrictions)

Start-up Implementation Plan: (Do a detailed project implementation plan. Attachment B is a possible format. If you would like an electronic copy, contact Laurie Evans. Please remember that the start-up must be underway in a local office by January 1, 2002.)

Project Budget – (Attach a Start-up budget. Note if you will cover costs within your current budget, or if you are requesting project dollars. If requesting additional funds, provide a justification.)

APPENDIX 3
COORDINATED SERVICES CHARTER

Coordinated Services Charter

(Previously known as "No Wrong Door")

April 2003

The purpose of this Charter is to affirm the vision, philosophy, objective, goals, and commitment to the development of a coordinated approach to delivering services to shared clients and partners throughout our communities.

VISION:

Coordinated Services is a part of the Department's Integration Initiative to ensure that client's receive unduplicated and coordinated services from DSHS agencies, contractors and community partners. The vision of the coordinated services approach to service delivery is to develop a systematic approach to providing holistic services to clients being served by multiple DSHS administrations, community partners, and contractors, and to provide a single point of access to these services through the case staffing model.

PHILOSOPHY:

Service integration is key to producing better outcomes for clients and staff. Utilizing a coordinated service approach to service delivery will promote an integrated model that is a way of doing business and not simply a mechanical program. This philosophy supports and encourages a comprehensive and holistic service delivery culture that incorporates positive and ongoing communication between clients and staff.

OBJECTIVES:

The objective of the Coordinated Services Initiative is to develop a statewide and local process for integrating services and leveraging resources for clients served by multiple DSHS Divisions, community partners and contractors. This coordination ensures that clients receive critical services without duplication.

GOALS:

- Leverage and maximize client, family, and community resources to identify client issues earlier and resolve sooner;
- Support clients through coordinated appointments;
- Develop a coordinated and collaborative success plan;
- Deliver a unified Department message;
- Increase Department and community communication;
- Develop better community partnerships; and
- Support staff in their efforts to support our clients.

COMMITMENT:

By signing the Coordinated Services Charter, we commit our support to our staff and our mutual clients. We agree to uphold the philosophy of the DSHS Coordinated Services Initiative. This support includes participating in case staffings and/or providing any updated information, input or available resources needed to develop and support a comprehensive client service delivery plan. DSHS Administrations may create a Coordinated Services project in your respective administration or participate with existing Coordinated Services projects in your area.

PARTICIPATING DIVISIONS & SIGNATURES:

Penny Black, ADSA Home & Community Services

Robin Cummings, JRA Institution Programs Division

Georgiann DeKay, ESA Division of Child Support

Ed Hidano, OAS Integration Initiative

Linda Rolfe, ADSA Developmental Disabilities

Ken Stark, HRSA Alcohol & Substance Abuse

LaVerne Lamoureux, CA Program & Policy

Nancy Zahn, CA Division of Licensed Resources

Carol Felton, Children's Administration

Karl Brimner, HRSA Mental Health Division

Michael W. Masten, ESA Community Services

Rachael Langen, ESA Child Care & Early Learning

Roxie Schalliol, ESA Employment & Assistance Programs

APPENDIX 4

FAMILIES AND COMMUNITIES TOGETHER

Families and Communities Together

Department of Social and Health Services
June 26,2003

Families and Communities Together

Mission Statement

The Mission of the Families and Communities Together integration Initiative is to join with families and children, and the communities in which they live, to provide a continuum of coordinated, effective care.

Families and Communities Together

Vision Statement

- to increase family safety and child well-being
- to foster healthy, educated, self-sufficient families
- to support strong, healthy and vibrant communities

Families and Communities Together

Service Delivery Continuum

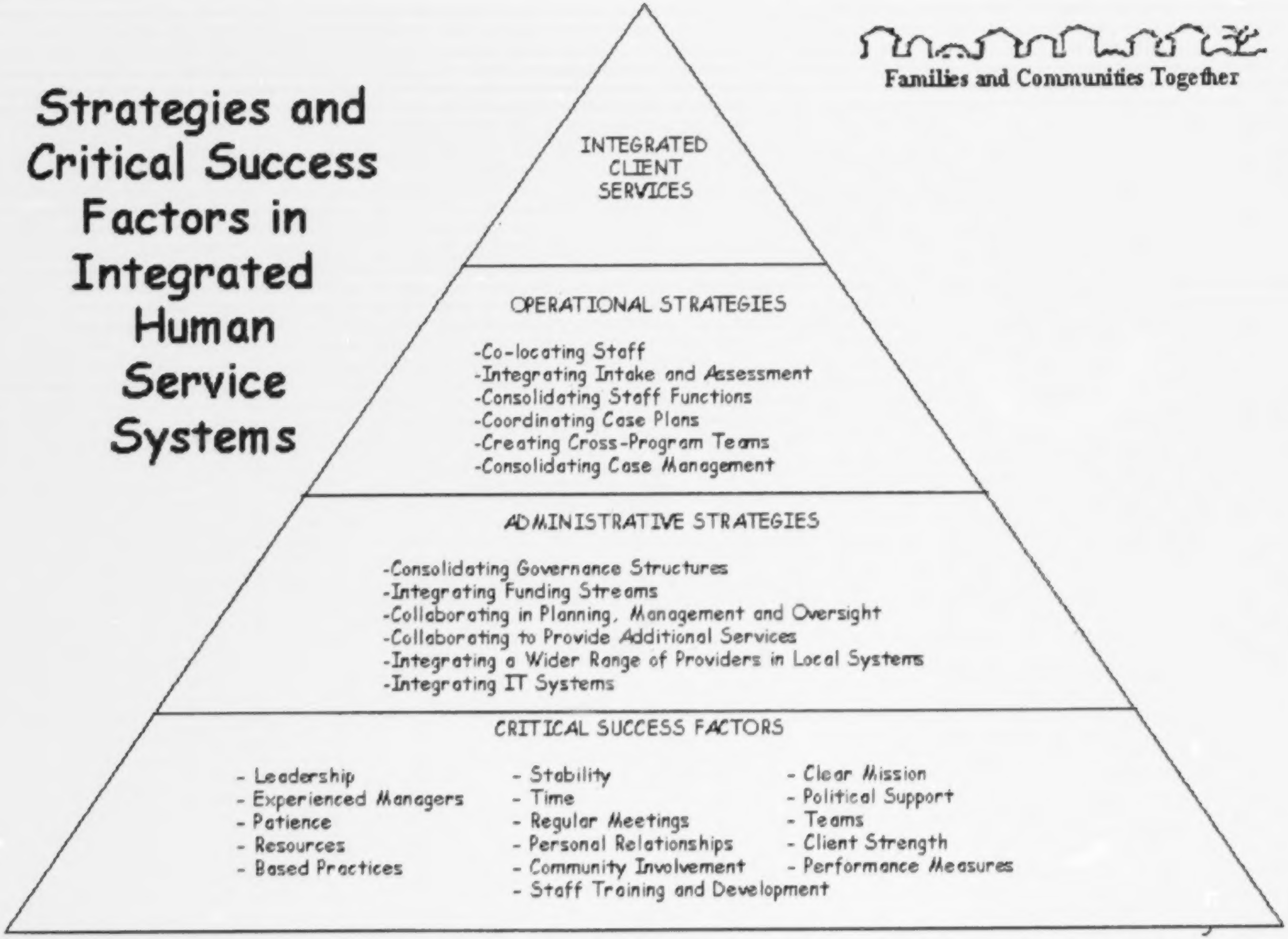
Communication — **Cooperation** — **Coordination** — **Collaboration** — **Integration** — **Consolidation**

Communication	Clear, consistent and non-judgmental discussions and giving or exchanging information in order to maintain meaningful relationships. Individual programs or causes are totally separate.
Cooperation	Assisting each other with respective activities, giving general support, information, and/or endorsement for each other's programs, services or objectives. Policy and consumer decisions are often/usually autonomous, but agencies, groups or individuals can comfortably work together toward mutual gains.
Coordination	Agencies or individuals engage in joint planning and synchronization of schedules, activities, goals, objectives and events. These efforts may be coordinated, but policy and budget decisions are still relatively independent. Program or advocacy accountability and outcomes are distinct however, mutual gains are desirable, and participants consider each other equal.
Collaboration	Agencies, individuals or groups willingly relinquish some of their individuality or autonomy in the interest of mutual gains or outcomes. True collaboration involves actual changes in agency, group or individual behavior, operations, policies, budgets, and even staff or power resources in order to support the collective goals or ideals.
Integration	Relationships evolve from collaboration to actual restructuring of services, programs, memberships, budgets, missions, objectives and staff. Missions, target populations, functions, and even power are shared so that the individual "parts" make up a stronger "whole". More individuality and autonomy are surrendered.
Consolidation	Agency, group or individual behavior, operations, policies, budgets, staff and power are untied and harmonized. Individual autonomy or gains have been fully relinquished towards adopted common outcomes and identity.

The Service Delivery Operations Continuum was developed by a community-based committee facilitated by the El Paso County, Colorado Department of Human Services.

Families and Communities Together

Strategies and Critical Success Factors in Integrated Human Service Systems



INTEGRATED CLIENT SERVICES

OPERATIONAL STRATEGIES

-Co-locating Staff
-Integrating Intake and Assessment
-Consolidating Staff Functions
-Coordinating Case Plans
-Creating Cross-Program Teams
-Consolidating Case Management

ADMINISTRATIVE STRATEGIES

-Consolidating Governance Structures
-Integrating Funding Streams
-Collaborating in Planning, Management and Oversight
-Collaborating to Provide Additional Services
-Integrating a Wider Range of Providers in Local Systems
-Integrating IT Systems

CRITICAL SUCCESS FACTORS

- Leadership
- Experienced Managers
- Patience
- Resources
- Based Practices
- Stability
- Time
- Regular Meetings
- Personal Relationships
- Community Involvement
- Staff Training and Development
- Clear Mission
- Political Support
- Teams
- Client Strength
- Performance Measures

From 2003 Rockefeller Institute of Government report - "Building Comprehensive Human Service Systems - Service Integration in the United States"

Project Parameters

Families and Communities Together

Clientele

- Families with children needing more than one administration's services

Services

- Programs to be integrated include CSD, DCS, CA, JRA, DDD, Alcohol and Substance Abuse, DVR, Tribes and Mental Health
- Families partner in choosing services they will need and use
- There will be a Family Needs Assessment and unified case plan
- There will be a continuum of care from prevention to intervention to post-intervention services
- As many points of integration as possible will be considered, and at a minimum:
    - physical integration (preferred)
    - case plan integration
    - some level of intake integration
    - some level of services integration
    - some level of information system integration

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Project Parameters

Family and Children's Services
Integration Initiative

Clientele

- Families with children needing more than one administration's services

Services

- Programs to be integrated include ESA, *CA*, JRA, DDD, Alcohol and Substance Abuse, and *Mental* Health
- Families partner in choosing services they will need and use
- There will be a Family Needs Assessment and unified case plan
- There will be a continuum of care from prevention to intervention to post-intervention services
- As many points of integration as possible will be considered, and at a minimum:
  - ▸ physical integration
  - ▸ case plan integration
  - ▸ some level of intake integration
  - ▸ some level of services integration
  - ▸ some level of information system integration

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Project Parameters (continued)

Administrative Structure

- Children's and Economic Services Administrations will co-lead the initiative
- The community Mental Health and Alcoholism and Substance Abuse systems will be key members of the integrated structure
- Spokane and Bellingham have been selected as project sites. If possible we would like one site to be community based; one site department based.
- Partnerships with the community are essential to the provision of a continuum of services

Project Parameters (continued)

Budget

- There is no new money, but the administrations commit to using current funds in more flexible ways
- We may find other sources for funds to support projects

Evaluation

- There will be an evaluation of processes and outcomes
- The model will be replicable

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Project Parameters (continued)

Budget

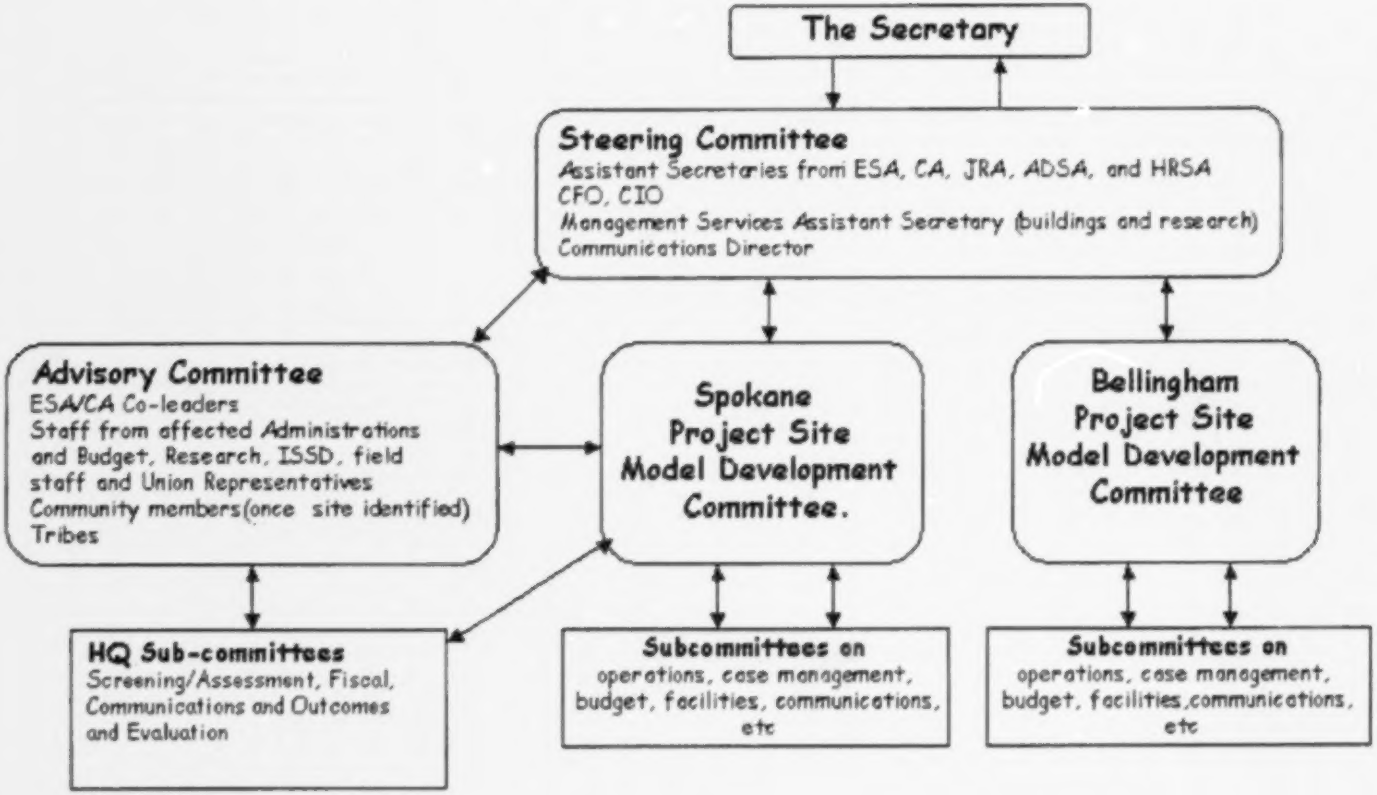
- There is no new money, but the administrations commit to using current funds in more flexible ways
- We may find other sources for funds to support projects

Evaluation

- There will be an evaluation of processes and outcomes
- The model will be replicable

Administrative Structure

Families and Communities Together



The Secretary

Steering Committee
Assistant Secretaries from ESA, CA, JRA, ADSA, and HRSA
CFO, CIO
Management Services Assistant Secretary (buildings and research)
Communications Director

Advisory Committee
ESA/CA Co-leaders
Staff from affected Administrations and Budget, Research, ISSD, field staff and Union Representatives
Community members(once site identified)
Tribes

Spokane Project Site Model Development Committee.

Bellingham Project Site Model Development Committee

HQ Sub-committees
Screening/Assessment, Fiscal, Communications and Outcomes and Evaluation

Subcommittees on
operations, case management, budget, facilities, communications, etc

Subcommittees on
operations, case management, budget, facilities,communications, etc

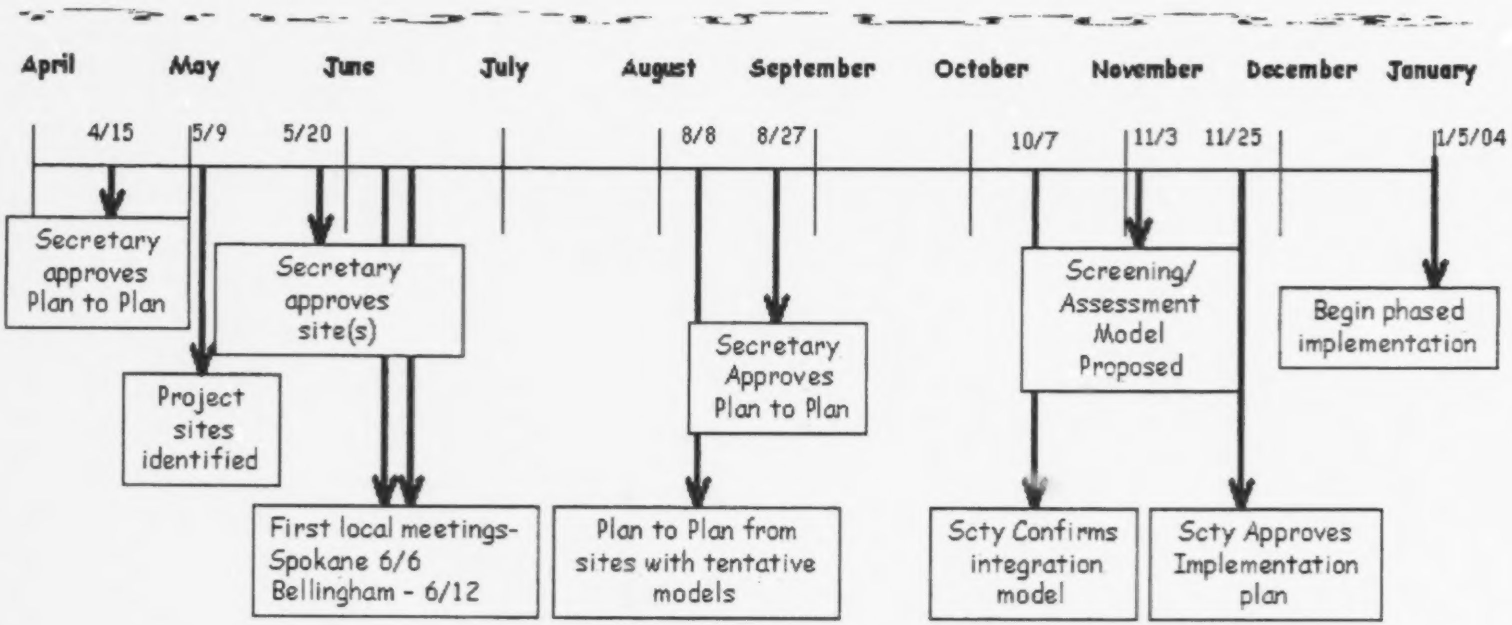
Families and Communities Together

Model Development Approach

- Gather data and review
- Develop desired outcomes based on data
- Develop model to achieve desired outcomes

Families and Communities Together

Project Timeline



April

May

June

July

August

September

October

November

December

January

4/15 Secretary approves Plan to Plan

5/9 Project sites identified

5/20 Secretary approves site(s)

First local meetings- Spokane 6/6 Bellingham - 6/12

8/8 Plan to Plan from sites with tentative models

8/27 Secretary Approves Plan to Plan

10/7 Scty Confirms integration model

11/3 Screening/ Assessment Model Proposed

11/25 Scty Approves Implementation plan

1/5/04 Begin phased implementation

WASHINGTON STATE
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Research and Data Analysis Division
Report Number 11.111

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